MEDI-CAL ASSUMPTIONS
May 2015
FISCAL YEARS 2014-15 & 2015-16

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.

AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA establishes 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 former practice of using various income disregards to adjust family income was replaced with a single 5% income disregard. The ACA simplifies the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The new standard allows 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 imposes 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 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 provides 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. **However, funding would have to be appropriated by Congress to implement this increase.**

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS Secretary-approved plan option, which allows DHCS to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows DHCS to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

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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 meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and unable to remain safely at home without the services.

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 supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select 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;

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- Assistance with accessing services;
- Crisis assistance planning;
- Periodic review.

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 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 services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, ~~and~~ Kern**, San Mateo, Santa Clara and Orange**). ~~Coverage into three additional counties (Orange, San Mateo and Santa Clara) is anticipated upon approval from CMS.~~ Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE)**, an Adult Residential Facility (ARF)** or through a home health agency while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is 3,700. ~~The waiver was approved from March 1, 2009 through February 28, 2014; a proposal to renew the waiver for an additional five years was submitted to CMS on November 27, 2013. The ALW is currently operating under extension through August 28, 2014. The five-year term of the waiver will be~~ **CMS approved a renewal of the ALW on August 28, 2014 effective from** March 1, 2014 through February 28, 2019.

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 **a managed care benefit** effective April 1, 2012, through an amendment to the “Bridge to Reform” 1115 Medicaid waiver; the CBAS portion continues through the life of the 1115 Demonstration. Eligible participants who meet the more stringent CBAS eligibility standards receive CBAS in approved CBAS centers.

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CBAS has been provided to all eligible participants since April 1, 2012. There is no cap on enrollment into this waiver service.

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. ~~The Department will submit a renewal to CMS requesting an extension of the waiver from January 1, 2015 through December 31, 2019.~~ **CMS approved a temporary extension for the IHO Waiver Renewal through March 30, 2015. The IHO Waiver Renewal period from January 1, 2015 through December 31, 2019 is pending CMS approval.**

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 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) 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:

- 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.

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- Have one or more medical co-morbidities.
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

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

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

The SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, CMS approved a waiver amendment on September 23, 2013 which adjusted 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:

- Administrative Expenses;
- Attendant care;
- Case management;
- Financial supplements for foster care;
- Home-delivered meals;
- Homemaker services;
- In-home skilled nursing care;
- Minor physical adaptations to the home;
- Non-emergency medical transportation;
- Nutritional counseling;
- Nutritional supplements;
- Psychotherapy.

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.

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Approved capacity of unduplicated recipients for this waiver is 4,490 in 2014, 4,570 in 2015 and 4,660 in 2016. The waiver is approved from January 1, 2012 through December 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 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. ~~Pending CMS approval~~ **Under the approved waiver, beginning July 1, 2014 through June 30, 2019**, capacity of unduplicated recipients ~~for~~ **are as follows:**

- **Waiver Year 1: 12,000**
- **Waiver Year 2: 10,932**
- **Waiver Year 3: 6,011**
- **Waiver Years 4 & 5: 5,624**

~~this waiver will be 12,000 in 2014 and 9,093 in 2015. The waiver is approved from July 1, 2009 through September 30, 2014. Pursuant to the Coordinated Care Initiative, the Department will submit an amendment to CMS requesting the inclusion of MSSP as a managed care component; the Department will also request the renewal of the waiver from October 1, 2014 through September 30, 2019.~~ **The decrease in Waiver capacity is a result of the Coordinated Care Initiative, which will phase out the MSSP Waiver by March 2017 and integrate as a managed care benefit in the seven Coordinated Care Initiative (CCI) counties.**

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

The DD Waiver provides home and community-based services to persons with developmental disabilities 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; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. Approved capacity of unduplicated recipients for this waiver is 110,000 in 2013, 115,000 in 2014 and 120,000 in 2015. The waiver is approved from March 29, 2012 through March 28, 2017.

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

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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 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 has renewed the SCAN contract through December 31, 2015.

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 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 Department is pursuing the continuation of grant funds through September 30, 2020.** The grant requires the Department to develop and implement strategies for transitioning Medi-Cal beneficiaries who

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have resided continuously in health care facilities for three months or longer back to a federally-qualified residence**.**

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~~**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.

The BTR will end on October 31, 2015. The Department plans to work with CMS to extend this Demonstration and/or submit a waiver renewal concept for 2015-16 and beyond. The Department assumes that all existing BTR Demonstration funding **for designated public hospitals** will continue. **At this time, the Department is not assuming the continuation of the $400 million for designated state health programs.**

The Department intends to seek a new five-year Waiver valued between $15 billion to $20 billion to accomplish various system transformation initiatives.

The new Waiver design has three core components:

- **Shared savings with the federal government of Waiver savings to be reinvested into the Medi-Cal Program;**
- **A redesign of Disproportionate Share Hospital (DSH) and Safety Net Care Pool Uncompensated Care funding under a global payment model to provide care to the remaining uninsured; and**
- **A set of delivery system transformation and alignment incentives that leads to the achievement of Waiver goals.**

Under the rubric of delivery system transformation and alignment incentives there are six concepts:

- **Incentives that foster partnerships and quality improvements in and among managed care plans, behavioral health systems, and providers;**
- **Fee-for-service quality improvement incentives in areas such as dental and maternity care where FFS continues to play a critical role in the delivery system;**
- **A successor to the DSRIP at California's public hospital systems;**
- **Workforce development strategies;**

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- **Incentives to promote access to housing and supportive services; and**
- **In places that are ready, the opportunity for counties and Medi-Cal plans to partner in local pilots, with providers and entities across the spectrum, that combine the aforementioned approaches of delivery system transformation and alignment.**

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.

Prior to July 1, 2014, rates for the Family category of aid (COA) were paid as one blended rate. Effective July 1, 2014, the department has split the Family COA in 2 groups: "Child (Under 19)" and "Family/Adult (19 and Over)".

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 necessarily 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

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SPD Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate. The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2014-15 rates, **50%** ~~40%~~ of this county specific rate was taken and multiplied by each plan's respective risk score and **50%** ~~60%~~ of each plan's plan specific rate was retained and added to the **50%** ~~40%~~ risk adjusted rate to establish a risk adjusted plan specific rate. 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.

~~2013-14 and 2014-15 Rates~~ 2014-15 and 2015-16 Rates

Overall, the rates represent a ~~3.63%~~ **3.5%** increase in FY ~~2013-14~~ **FY 2014-15** over the previous fiscal year rates (based on a fiscal year comparison). Rates for ~~2014-15~~ **FY 2015-16** represent a ~~3.5%~~ **1.9%** increase over the ~~2013-14~~ **2014-15** fiscal year rates.

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.

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.

In the absence of legislation, the AB 1629 facility-specific rate methodology, QAF, and QASP are scheduled to sunset. The Department is assuming continuation of the program beyond the July 31, 2015 sunset date with a 3.62% total annual rate increase. The QASP will continue at FY 2014-15 levels rather than setting aside a portion of the annual rate increase. The Department has proposed Trailer Bill Language to extend the program until July 31, 2020.

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

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

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

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

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

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

Methodology by Type of LTC Facility

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

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

PROVIDER RATES

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

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective June 2014, providers of services to developmentally disabled clients have rates set 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 65th percentile established in 2008-2009, with none receiving a rate lower than 90% of the 2008-2009 65th 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.

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REVENUES

1. Revenues

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

FY 2013-14:	$ 35,640,000		ICF-DD Quality Assurance Fee
	$ 503,813,000		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ 7,361,000		ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,793,000		Freestanding Pediatric Subacute Quality Assurance Fee
	$ 798,599,000		MCO Tax
	$3,695,728,000		Hospital Quality Assurance Revenue Fund (4260-610-3158)
	$ 11,250,000		Emergency Medical Air Transportation Fund (EMATA)
	$5,054,184,000		Total
FY 2014-15:	$ ~~25,742,000~~	**27,409,000**	ICF-DD Quality Assurance Fee
	$ 522,095,000		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~7,358,000~~	**9,120,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,862,000		Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~1,432,849,000~~	**1,407,405,000**	MCO Tax
	$ 3,991,796,000		Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ ~~11,250,000~~	**9,867,000**	Emergency Medical Air Transportation Fund (EMATA)
	~~$5,992,952,000~~	**5,811,758,000**	Total
FY 2015-16:	$ ~~25,742,000~~	**27,886,000**	ICF-DD Quality Assurance Fee
	$ ~~535,233,000~~	**540,994,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~7,358,000~~	**6,847,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,862,000		Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~1,909,157,000~~	**1,733,235,000**	MCO Tax
	$ 4,600,535,000		Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)

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$	~~11,250,000~~ **9,867,000**	Emergency Medical Air Transportation (EMATA) Fund
	~~$7,091,137,000~~ **6,390,017,000**	Total

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

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 was effective retroactive to January 1, 2009.~~ **SB 78 (Chapter 33, Statutes of 2013) provides for a statewide tax on the total operating revenue of Medi-Cal Managed Care Plans. Although this tax is effective through June 2016, it has been deemed out of compliance with federal regulations and will be replaced with a new tax beginning July 1, 2016. Proposed legislation provides that the new tax will apply to the Medi-Cal revenue of most managed care plans in the state, with some exemptions. The new tax structure will meet federal requirements while achieving the same GF savings as the previous tax and also providing suffucuent funding to restore the 7% reduction in the In-Home Supportive Services Program.**

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee is deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund is 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 is also 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, Statues 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 authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is 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

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health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014, through December 31, 2016. This extension authorizes the collection of a quality assurance fee from non-exempt hospitals. The fee is deposited into the Hospital Quality Assurance Revenue and is used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed health care plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

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

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

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

1. **County Administration Base**

The Department is in the process of finalizing a Request for Offer (RFO) for approval to hire a contractor to begin evaluating county processes and time-studies associated with the new budgeting methodology. The Department anticipates the workgroup to begin meeting in the spring of 2015.

2. 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

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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 March 31, 2015, by HR 4302, the Protecting Access to Medicare Act of 2014.

3. 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 March 31, 2015, by HR 4302, the Protecting Access to Medicare Act of 2014.

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

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the 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.

5. *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.

6. Electronic Asset Verification Program

Due to the requirements imposed by HR 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

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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.

7. 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.

8. Medi-Cal Inpatient Services for Inmates

AB 720 (Chapter 646, Statutes of 2013) requires the suspension of Medi-Cal benefits for all Medi-Cal eligible inmates, regardless of age. This new state law authorizes county boards of supervisors, in consultation with the county sheriff, to designate an entity or entities to act on behalf of county inmates and assist county jail inmates apply for a health insurance affordability program.

9. **Refugee Resettlement Program**

The federal Refugee Resettlement Program provides medical services to refugees during their first eight months in the United States. In California, these medical services are provided through the Medi-Cal delivery system and funded with 100% federal funds through a federal grant. The California Department of Public Health administers the Refugee Resettlement Program federal grant. With the Affordable Care Act, the majority of refugees is expected to be eligible for Medi-Cal and will no longer receive their medical services through the Refugee Resettlement Program. The Department expects the number of eligibles receiving their medical services under the Refugee Resettlement Program to be negligible. All medical costs associated with the Refugee Resettlement Program will be funded 100% through the federal grant.

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AFFORDABLE CARE ACT

1. 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 have selected one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider. **Public hospital health systems will be paid at least cost for their new Medi-Cal population.**

The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be $724.9 million in FY 2014-15 and **$743.158 million in** FY 2015-16.

2. Disproportionate Share Hospital Reduction

The ACA reduction in the Disproportionate Share Hospital (DSH) allotments was to have gone into effect on October 1, 2013: instead, ~~HR 4302 (2014)~~ **HR 2 (2015)** was enacted on ~~April 1, 2014~~ **April 16, 2015**, which delays the reduction until ~~October 1, 2016~~ **October 1, 2017**. The ACA nationwide reduction of State DSH allotments will occur in ~~FY 2016-17~~ **FY 2017-18**. The reduction for each state will be determined by CMS.

For federal fiscal year ~~2017~~ **2018**, an aggregate of ~~$1.8~~ **$2** billion in reduction for all states has been determined, but state specific reductions have not been released by CMS.

3. IRS Reporting for Medi-Cal Minimum Essential Coverage

Beginning in 2014, the Affordable Care Act (ACA) required most U.S citizens and legal residents to have qualifying health insurance coverage or pay a tax for not carrying insurance, known as the individual mandate. Internal Revenue Code Section 6055 finalized and published by the Internal Revenue Service (IRS) on March 10, 2014 requires that all State Medicaid Agencies meet the information reporting requirements

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to support the individual mandate reporting. The Department is required to comply with the minimum essential coverage (MEC) reporting requirements for tax year 2015. The state will be subject to a penalty if it does not show good faith in attempting to implement these new reporting requirements. **The Department will develop a system to report information about Medi-Cal consumers with MEC to the IRS.** The Department is still researching the fiscal impact and options on the best way to implement/leverage a system for this new reporting requirement.

BENEFITS

1. State-Only Anti-Rejection Medicine Benefit Extension

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

HOME & COMMUNITY BASED-SERVICES

1. AB 398—Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project. ~~Instead~~ **In conjunction with DOR**, the Department ~~is exploring ways to serve~~ **has explored serving** this population through ~~the Assisted Living Waiver~~ **other HCBS waivers**.

2. Assisted Living Waiver Rate Structure

This assumption has been deleted, as this is now a new assumption.

3. Medicaid Health Home Services Benefits

The Medicaid Health Home Services Program was authorized by AB 361 (Chapter 642, Statutes of 2013). ~~This program would manage medically complex patients with patterns of high utilization and multiple chronic conditions who could benefit from intensive primary care services. Implementation of health homes includes focused provider technical assistance for in-depth individual primary care practice transformation assistance. Health home~~

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~~services include comprehensive care coordination and patient and family support. Since the program is in its early planning stages, the earliest possible program implementation will be in 2016. Funding will be 90% Federal Funds and 10% State General Funds for the first two years of this program. Thereafter, funding will be 50% Federal Funding and 50% State General Funding.~~ **This program would manage medically complex patients with patterns of high cost, high utilization and multiple chronic conditions who could benefit from intensive care management services. Health home services include patient and family support, and comprehensive care coordination of physical health, behavioral health, and community-based long term services and supports which will result in reduced hospitalizations and emergency department visits, improved patient engagement and decreased costs. Since the program is in design and development stages, the earliest possible program implementation will be in 2016. Funding will be 90% Federal Funds and 10% State General Funds for the first two years of this program. Thereafter, funding will be 50% Federal Funding and 50% State General Funding. The 10% state share during the first two years will be funded by The California Endowment at up to $25M/year. Per Assembly Bill 361, implementation of Health Homes is subject to several conditions, including cost neutrality and an evaluation after the first two years.**

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

1. Average Acquisitions Cost as the New Drug Reimbursement Benchmark

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

2. Federal Upper Limit

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

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Department plans to implement the FULs, after federal regulations have been published and/or final FULs are provided by CMS.

3. **State Supplemental Drug Rebates – Managed Care**

State supplemental rebates for drugs are negotiated by the Department with drug manufacturers to provide rebates in addition to the mandatory federal rebates already collected. SB 870 (Chapter 40, Statute of 2014) authorizes the Department to include utilization data from MCOs to determine and collect state supplemental rebates for prescription drugs added to the Medi-Cal Statewide Contract Drug List pursuant to Welfare & Institutions Code section 14105.33. Examples of prescription drugs subject to MCO state supplemental rebates may include drugs to treat diseases such as, but not limited to, cancer, HIV/AIDS, hemophilia and hepatitis C. The Department is pursuing contracts for these rebates.

DRUG MEDI-CAL

1. 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.

MENTAL HEALTH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

1. Change in PACE Rate Methodology

This assumption has been withdrawn.

PROVIDER RATES

1. Martin Luther King, Jr. Hospital (MLK) - Inpatient Hospital Funding

This assumption has been deleted as this is now a new policy change.

2. **Newborn Screening Program Fee Increase**

AB 1559 (Chapter 565, Statute of 2014) requires the California Department of Public Health (CDPH) Genetic Disease Screening Program (GDSP) to expand statewide screening of newborns to include screening for adrenoleukodystrophy (ALD) as soon as ALD screening is adopted by the federal Recommended Uniform Screening Panel

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(RUSP). GDSP expects the federal Discretionary Advisory Committee on Heritable Disorders in Newborns and Children to recommend inclusion of ALD within 2 years.

Once the ALD screening is adopted by the RUSP, GDSP will be required to add ALD to the Newborn Screening Program (NSP) and begin screening all babies in California for the disease. The addition of ALD to the NSP will require an estimated $11 per patient.

SUPPLEMENTAL PAYMENTS

1. Designated Public Hospitals – Seismic Safety Requirements

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

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

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

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

2. Hospital Inpatient Rate Freeze

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

3. **Capital Project Debt Reimbursement**

In February 2014, Los Angeles County requested reimbursement of a $322 million bond project for the Construction Renovation and Reimbursement Program (CRRP). The project was completed in April 2014. The Department is currently working with Los Angeles County to determine eligibility for this project under the CRRP program.

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OTHER: AUDITS AND LAWSUITS

1. SB 1103 Litigation

- *OAHA Administrative Appeals and Superior **and Appellate** Court Actions*

In 2005, approximately 100 California hospitals sued the Department to challenge the validity of a Medi-Cal reimbursement rate limit for in-patient services provided by non-contract hospitals that was enacted by Senate Bill 1103 (See *Mission Hospital Regional Medical Center v. Douglas*, above). During the pendency of this litigation, more than 50 non-contract hospitals filed administrative appeals with the Department's Office of Administrative Hearings and Appeals (OAHA). The 50 some hospitals include both *Mission* litigants and non-*Mission* litigants. All challenge SB 1103's validity and, so, seek a retroactive reimbursement rate increase for FY 2004-05, based on SB 1103's alleged invalidity.

OAHA has been holding these administrative appeals in abeyance during the *Mission* litigation, which finally terminated in early 2014. **Currently, 23 cases remain in abeyance.** Since 2013, OAHA has dismissed at least 17 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by *res judicata*, that is, by the *Mission* litigation's challenge to SB 1103. In ~~five~~ **one** case~~s~~, the hospital has ordered the administrative record but the petition for writ of mandate has not yet been filed. In ~~12~~ **18** cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petition and the hospitals have appealed. (*Dignity Health v. Douglas*; *Hi-Desert Med. Center v. Douglas*, & *Modoc Med. Center v. Douglas*). In the ~~fourth~~ **four other** case**s**, the superior court ~~granted~~ **denied** the writ petition and the Department has appealed **one**. (*George L. Mee Mem'l Hosp. v. Douglas*). **The Department has not yet filed a notice of appeal in the other two cases. (*Desert Valley Hosp. v. Douglas & Ridgecrest Regional Hosp. v. Douglas*.)**

To date, no court has ruled on SB 1103's substantive validity.

2. California Hospital Association v. Shewry

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

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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. **On October 12, 2011, the United States Supreme Court denied the Department's petition for certiorari (i.e., review) of the Court of Appeal decision.** The case **was then** remanded back to the trial court for further litigation concerning the plaintiff's challenge to the rates paid for rate years 2001-02 to present. So far, there has been some additional discovery, but no other activity has occurred since the remand. **Additional discovery was conducted during February and March of 2012, but no other activity has occurred since the remand and it is the plaintiffs' obligation to pursue further action at the trial court level.**

3. 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 3, Statutes of 2008), violate various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(8) and 1396a(a)(30). The status of the case is as follows:

- 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 with respect to only the 17 plaintiff hospitals,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,
- On February 22, 2012, the United States 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
- On January 9, 2014, the Ninth Circuit issued a decision reversing and vacating the November 2009 injunction and remanded to the district court for further proceedings.
- **On October 10, 2014, the district court stayed further proceedings, pending a decision by the United States Supreme Court in the case of *Armonstrong, et al.* v. *Exceptional Child Center, et al.* The Court in *Armstrong* will be deciding whether the Supremacy Clause of the United States Constitution confers a right of action upon providers to sue states for violation of 42 U.S.C. section 1396a(a)(30)(A), which is one of the federal Medicaid provisions at issue.**

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

This lawsuit challenges the 10% reduction required by AB 5 (Chapter 3, Statutes of 2008) 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:

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

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government. **On October 22, 2014, the Department submitted a request to the federal government for approval.**

5. 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.

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- 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 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.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government. **On October 22, 2014, the Department submitted a request to the federal government for approval.**

6. AB 97 Litigation

~~Five~~ **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 approved a State Plan Amendment (SPA) concerning these reductions, was 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. On March 8, 2012, the district court issued an order

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modifying the injunction to exclude from its effect services rendered prior to December 28, 2011 that were not reimbursed prior to that date. 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 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. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes. The lawsuit has been remanded to the federal district court where plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments for DP/NFs.

- *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. 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 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. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the plaintiffs have indicated they intend to pursue a new court order that would prohibit the Department from implementing the AB 97 payment reductions for NEMT services.

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

  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,

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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 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. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. This case has been remanded to the federal district court where the plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments.

- *Eastern Plumas Healthcare District, et al. v. Dept. of Health Care Services, et al.*

  Plaintiffs are nine hospitals that operate nursing facilities that are a distinct part of a hospital (DP/NFs). This lawsuit was filed May 2014 in San Francisco Superior Court to challenge the validity of the AB 97 reduced rates for DP/NFs that are to be implemented for the period June 1, 2011 through September 30, 2013 pursuant to the federally approved State Plan.

7. *California Hospital Association v. David Maxwell-Jolly*

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

On February 24, 2010, the district court issued a preliminary injunction against the 10% reduction for small and rural hospitals and the freeze in rates for hospital based nursing facility and sub-acute services. On appeal, the Ninth Circuit granted the Department's motion for a stay of appellate proceedings pending petitions for certiorari in Maxwell-Jolly v, Independent Living Centers and Maxwell-Jolly v. California Pharmacists Association. On

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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.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government. **On October 22, 2014, the Department submitted a request to the federal government for approval.**

8. ABX3 5 Litigation

- *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. 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. This ruling became effective on September 26, 2013. Accordingly, beginning September 26, 2013, the Department began reimbursing FQHCs and RHCs for podiatry, optometry and chiropractic services. The parties are currently litigating the form of the judgment.

- *American Indian Health Services, Inc., et al. v. Toby Douglas, et al.*

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Petitioners and plaintiffs, which are Federally Qualified Health Centers (FQHC), filed a Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief. Petitioners and plaintiffs seek an order requiring the Department to process and pay claims for adult dental, podiatry, and chiropractic services that petitioners provided to eligible Medi-Cal beneficiaries during the period July 1, 2009 to September 26, 2013 pursuant to 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (20), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9th Cir. 2013) 738 F.3d 1007.

9. Managed Care Potential Legal Damages

Four health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for rate years 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*
- *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 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. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The Department and Santa Clara have also entered into a settlement agreement. **In November 2014, the Department fully paid Santa Clara in accordance with the terms of the settlement.**

The Department is also currently in the process of settling a similar rates dispute with Medi-Cal Managed Care Plan Inland Empire Health Plan (IEHP). This case is currently pending before the Office of Administrative Hearings and Appeals and settlement discussions are on-going.

10. *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 appealed. On November 3, 2011,

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the Ninth Circuit Court of Appeals issued an unpublished decision affirming in part and reversing in part the lower court's dismissal of the case. Plaintiff's claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA 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. The Department filed a motion to continue the stay, 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 submitted the SPA on November 1, 2013. CMS approved the SPA on January 30, 2014. Following DHCS' motion the Ninth Circuit vacated the judgment and remanded to the district court to consider the impact of CMS' approval. At the June 18, 2014 hearing on the mandate of the Ninth Circuit Vacating and Remanding, the district court changed the findings of fact to reflect the SPA approval, but re-issued the permanent injunction. DHCS plans to appeal to the Ninth Circuit.

On November 14, 2014, the Ninth Circuit granted the Director's motion to stay the district court order pending our appeal.

~~38. *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 March 31, 2012, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective April 1, 2012. The settlement agreement was in effect until August 31, 2014.~~

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11. *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**, and those mediation activities are still ongoing**.

12. *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. 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 Department is currently in the process of securing rate information from other third party payors to conduct this comparison. The Court set a hearing for September 19, 2014, at which the Department must either submit a revised annual report with the third party payors' information, or show cause why it should be excused from doing so.~~

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The Court granted Petitioners' writ on the third cause of action (duty to review rates annually) and ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. On October 24, 2014, the Court found the Department's 2011 rate review report and the analyses of the five third-party payor rates data satisfactory, and discharged the Department's ministerial duty under Welfare and Institutions Code section 14079. The Court also found that the Department satisfactorily demonstrated its intention of conducting this rate review on an annual basis.

13. 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.

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

Petitioners sought a writ of mandate that would have required 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 contended that the Medi-Cal program should change from a cost-avoidance system to a "pay and chase" recovery process. The petition was denied and petitioners have appealed.

15. *Saavedra, et al. v. Toby Douglas, California Department of Health Services Lawsuit*

In this writ litigation, petitioners allege that the Department improperly transitioned Seniors and Persons with Disabilities from the fee-for-service Medi-Cal delivery system into the managed care Medi-Cal delivery system by failing to appropriately respond to and process beneficiary requests to be exempted from the transition to managed care ("medical exemption requests"). Petitioners assert that the Department is applying improper standards in deciding medical exemption requests. The Department has revised the denial letter, denial codes and the regulation governing medical exemption requests and is resuming settlement discussions with Petitioners' counsel. ~~If the parties are unable to agree to a settlement, the writ petition is scheduled for hearing on December 4, 2014.~~ **The Department has revised the denial letter, denial codes and the Medical Exemption Request form and is resuming settlement discussions with Petitioners' counsel. Despite on-going settlement discussions, several issues remain unresolved. If these issues are not resolved in the next few months, it is likely that the hearing on the writ petition will go forward on May 5, 2015.**

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16. *Farrow v. Toby Douglas, Director of DHCS, et al.*

Petitioner is a disabled Medi-Cal beneficiary whose services were reduced when he reached the age of twenty-one (21). Petitioner alleges that the Department failed to provide petitioner with medically necessary in-home nursing services to which he was entitled under the Medi-Cal program, thereby placing him at risk of institutionalization in violation of state and federal anti-discrimination laws. Petitioner also alleges that the Department failed to comply with statutory and Constitutional due process requirements, including timely notice of termination of benefits, a pre-termination hearing, and aid pending a hearing decision. In addition, petitioner contends that the Department denied him a fair administrative hearing. No hearing has been scheduled. **It is petitioner's obligation to set this matter for hearing and they have not done so. If petitioner does not set a hearing date, the Department may move to dismiss in 2016.**

17. *T. Michael, LLC v. Toby Douglas, Director of DHCS*

Plaintiff, on its own behalf and as a class action representative for Residential Care Facilities for the Elderly (RCFEs), challenges the Department's implementation of the 10% payment reductions enacted pursuant to Assembly Bill (AB) 97 (Statutes of 2011) on services provided under the Assisted Living Waiver (ALW).

In April 2013, the Department, pending waiver amendments, reversed its decision to implement the AB 97 reductions on RCFEs and services provided under the ALW. In May 2013, the Department instructed its contractor-agent to process the Erroneous Payment Corrections (EPCs) retroactive to June 2011. The Department's contractor-agent failed to process the EPCs within the required contractual deadline of 120 days.

In April 2014, plaintiff filed a state class action lawsuit and seeks to: (1) have the EPCs processed within 10 days; (2) receive interest; (3) attorneys' fees.

As of May 2014, the Department processed and paid the EPC for the entire RCFEs class. Parties are disputing interest and attorneys' fees.

18. *Asante, et al. v. Department of Health Care Services, et al.*

Plaintiffs are 18 out-of-state hospitals that challenge the validity of Medi-Cal reimbursement paid to out-of-state hospitals for hospital inpatient services. They filed this lawsuit in June 2014 in San Francisco Superior Court. Plaintiffs contend that aspects of the new diagnosis-related group (DRG) reimbursement policy discriminate against out-of-state hospitals in violation of the Interstate Commerce clause and Equal Protection clause of the United States Constitution. They further contend that the Department is violating federal Medicaid law by not making disproportionate share hospital (DSH) payments to qualifying out-of-state hospitals.

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19. *Riverside Recovery Resources v. Riverside County Department of Mental Health, et al.*

On July 30, 2014, Plaintiff Riverside Recovery Resources served the Department an amended complaint filed July 22, 2014 in Riverside County Superior Court against the Department and Riverside County Department of Mental Health contesting disallowances of monies for Drug-Medi-Cal services provided to minors in Riverside County schools. ~~Plaintiff Riverside Recovery Resources filed a complaint April 10, 2014 in Riverside County Superior Court against Riverside County Department of Mental Health and the State of California contesting disallowances of monies for Drug-Medi-Cal services provided to minors in Riverside County schools.~~ The listed cause of actions stated include Writ of Administrative Mandamus and Breach of Contract related to disallowances stemming from a Department~~/DMC~~ **Post Services Post Payment** audit that found services were claimed for duration of time in which Riverside Recovery Resources **satellite sites were** ~~was~~ not lawfully certified for reimbursement. As a result, Riverside County has withheld reimbursement for services during the period of time Riverside Recovery Resources was found to be in non-compliance. Plaintiff disputes the facts upon which the non-compliance findings were based, and denial of due process in the administrative appeal process. ~~A status conference is set for July 24, 2014.~~ **A trial setting conference is set for February 17, 2015.** ~~The Department has not been served with the current complaint.~~

20. *Westside Center for Independent Living, et al v. DHCS*

On July 2, 2014, seven petitioners filed a lawsuit in state court against the Department and its director asking the court to enjoin the implementation of the Coordinated Care Initiative (CCI) and to disenroll beneficiaries currently enrolled in CCI. CCI is a joint CMS/Department project seeking to coordinate care for dual eligible beneficiaries. Petitioners allege that the Department was without authority to implement CCI and violated certain statutory provisions and due process by failing to comply with necessary notice requirements. On July 11, 2014, the court denied petitioners' ex parte application for a temporary restraining order. The court continued the matter for hearing until August 1, 2014, to decide whether the court should enjoin CCI pending a hearing on the merits. On August 1, 2014, the court denied petitioners' motion for preliminary injunction. Petitioners ~~will likely~~ **did not** appeal **the order denying the motion for preliminary injunction**. **The Department filed a demurrer seeking to dismiss the petition, which was heard on January 9, 2015. The demurrer was overruled. There is no hearing date currently set for a decision on the merits of the case.**

21. *Placentia-Linda Hospital, et al. v. California Department of Health Care Services*

The lawsuit was filed in San Francisco County Superior Court on April 9, 2014. Plaintiffs are five hospitals that contend that the Department implemented Medi-Cal payment reductions for non-contract hospital inpatient services from July 1, 2008 through April 12, 2011, as required by Assembly Bill 5 (statutes 2008) and Assembly Bill 1183 (statutes 2008), in violation of 42 United States Code sections 1396a(a)(13) and 1396a(a)(30)(A). Plaintiffs seek a court order requiring the Department to retroactively pay

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them the additional money they would have received if the Department had not implemented the reductions.

22. ***Korean Community Center of the East Bay, et al. v. Toby Douglas, et al.***

Petitioners seek a preliminary injunction and writ of mandate preventing DHCS from terminating Medi-Cal benefits for those beneficiaries who failed to return any renewal information during the 2014 renewals, until the renewal form (the Request for Tax Household Information or RFTHI) is translated into all threshold languages and the 90 day cure period is included in all notices of action issued by the counties. Petitioners also claim that the ex parte process required by state and federal law is not being utilized and fails to comply with the law.

Petitioners sought a temporary restraining order to prevent counties from terminating beneficiaries. At the hearing on November 18, 2014, the TRO was denied for lack of evidence of exigency and irreparable harm. A hearing on Petitioners request for Preliminary Injunction (Petitioners asked the court to make their request for TRO and Writ petition into a request for Preliminary Injunction) was held on December 9, 2014. Because Petitioner's submitted over 200 pages of new evidence in reply to the Department's opposition brief, the court ordered the Department to further brief the issue and held a further hearing on December 23, 2014. The parties await the court's opinion and order.

The parties have stipulated to continue the February 2, 2015, case management conference. The court has not issued a ruling regarding the petition for preliminary injunction. Rather, the court requested, and the parties submitted, supplemental briefing on February 2, 2015. The issues raised by the court in the request for supplemental briefing go to the core of the issues raised regarding translations of Department forms into all threshold languages. As such, it is difficult to predict what the court will do. At the last hearing, the court indicated it was inclined to give greater weight to the Department's arguments; however, with this request for additional briefing, the Department can no longer be confident of the court's leanings.

OTHER: REIMBURSEMENTS

1. Federal Upper Payment Limit

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

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

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2. 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 2012-13), the June 30, 2013, Medi-Cal accrual amounts were estimated to be $2.23 billion state General Fund, $5.09 billion federal funds, and $1.47 billion special fund, for a total of $8.79 billion.

3. 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.

4. Refund of Recovery

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

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5. **Payment Deferrals**

The Department issues Fee-For-Service provider payments weekly, this process is referred to as the checkwrite. Starting in FY 2004-05, the Department implemented (1) an additional week of claim review prior to the release of provider payments starting in July 2004, this shifts the payment s of the Fee-For-Service checkwrite by one week, and (2) the last checkwrite in June of each fiscal year has been delayed until the start of the next fiscal year. Beginning in FY 2012-13, an additional checkwrite and the last month of managed care capitation payments are delayed at the end of each fiscal year until the start of the next fiscal year.

OTHER: RECOVERIES

1. Additional Personal Injury Recoveries

In *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, the United States Supreme Court held that a Medicaid agency's lien recovery from a Medicaid beneficiary's tort settlement is limited to the portion of the settlement that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. Then, in *Wos v. E.M.A.* (2013) 133 S.Ct. 1391, the U.S. Supreme Court held that states may not adopt a one-size-fits-all mechanism for allocating medical expenses, such as deeming a specific percentage of a tort settlement or award to be the medical expenses portion. Instead, states must have processes for determining and recovering only that portion that is attributable to medical expenses.

In response to the *Ahlborn* ruling, California amended Welfare & Institutions (W&I) Code Section 14124.76 and enacted W&I Code Section 14124.785.

On December 26, 2013, H.J. Res. 59 (federal Budget Act) was signed into law. Section 202 of the Act addresses Medicaid third party liability. Section 202, effective October 1, 2014, essentially supersedes *Ahlborn* and *Wos* by allowing states to recover from the full amount of a beneficiary's tort settlement, instead of only the portion designated for medical expenses. The implementation date has been delayed to October 1, 2016. The nullification of the *Ahlborn* ruling is expected to increase savings for the Department.

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

1. Dental Program Utilization Controls Assessment

In an effort to improve the provider experience and to encourage further provider participation, the Department is evaluating program utilization controls and other administrative requirements to make the program more provider friendly while maintaining

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program integrity. The results of this effort are anticipated to be increased provider participation and potentially increased beneficiary utilization.

2. Teledentistry

The Department considers Teledentistry a cost-effective alternative to dental services provided in-person, predominantly in underserved areas. Teledentistry is a way for dentists to deliver services to their patients that is similar to in-person care. The standard of care is the same whether the patient is seen in person or through the Teledentistry environment. This method of providing services would allow for improved access to care options for beneficiaries who typically experience access to care issues.

3. Dental Managed Care Experience Based Rates

The rates for the Dental Managed Care plans are currently based on Fee-for-Service program experience. The Dental Managed Care plans believe that the capitation rates they receive do not adequately compensate them for all the duties and benefits they provide. The Department is considering developing a rate setting methodology based on actual plan experience.

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY

AFFORDABLE CARE ACT
PC 28 USPSTF Grade A and B Recommendations

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

ELIGIBILITY
PC 9 Refugees

AFFORDABLE CARE ACT

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS
OA 48 CCS Program Pilots Evaluation

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 53 Pediatric Mobile Vision Project

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL