

Department of Health Care Services (DHCS)



**CMS-IHS I/T/U Outreach & Education Training
Medi-Cal Overview and Update**

May 24, 2012



What is Medicaid?

- An entitlement program created in 1965 under Title XIX of the Federal Social Security Act
- Makes available medically necessary health care services for low income families, children, pregnant women, seniors and persons with disability who meet criteria for program services
- Is a federal-state partnership which plays a key role in health care delivery systems
- Makes available federal funding, known as federal financial participation (FFP) for programs that are in compliance with applicable federal Medicaid statutes, regulations and policies

What is Medicaid? (cont.)

- States are able to receive FFP, based on their federal medical assistance percentage (FMAP), for program administration and covered medical services through federally approved:
 - State Plan and State Plan Amendments (SPAs), which are the formal “contracts” with the federal government in administering Medicaid programs; and
 - Federal waivers, which allow states to “waive” certain rules pertaining to program implementation.

So What is Medi-Cal?

- Medi-Cal is California's version of Medicaid established in 1966 under the Welfare & Institutions Code, starting at Section 14000
 - Program regulations are found under the California Code of Regulations, Title 22, Division 3
 - Approximately 8.3 million enrollees in January 2012
 - Providers include over 400 hospitals and 130,000 private providers
- Is administered by DHCS, which serves as the Medicaid Single State Agency and is responsible for ensuring the program is administered in accordance with applicable federal and state statutes, regulations and policies
 - Fiscal Year 2011-12 budget is \$51 billion. General Fund is \$16 billion.

So What is a State Plan?

- The **State Plan** - the official contract between the state and federal government by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding
- Is developed by the Single State Agency and is submitted to and approved by the Centers for Medicare and Medicaid Services (CMS), the federal Medicaid partners
- Describes the nature and scope of Medicaid programs and gives assurances that it will be administered in accordance with the specific requirement of Title XIX of the Federal Social Security Act, Code of Federal Regulations, Chapter IV, and other applicable official issuance of the applicable State
- California's State Plan is over 1,400 pages and can be accessed online at:
<http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx>.

What is a State Plan Amendment?

- State Plan Amendment (SPA) - any formal change to the State Plan
- Approved State Plans and SPAs ensures the availability of federal funding for the state's program
- CMS reviews all State Plans and SPAs for compliance with:
 - Federal Medicaid statutes and regulations
 - State Medicaid Manual
 - Most current State Medicaid Directors' Letters which serve as policy guidance.

What Are Medicaid Waivers?

- They are not part of the State Plan. In general, Medicaid Waivers allow:
 - The federal government to waive specified provisions of Medicaid law (Title XIX of the Social Security Act (SSA) by the Secretary of the U.S. Department of Health and Human Services (HHS))
 - Flexibility and encourage innovation in administering its Medicaid program to meet the health care needs of its populations
 - Ability to provide medical coverage to individuals who may not otherwise be eligible and/or provide services that may not otherwise be allowed under the regular Medicaid rules.

Types of Medicaid Waivers

- Two sections of the SSA, Sections 1115 (Research and Demonstration Waivers) and 1915 (Program Waivers), allow states to apply to the federal government to obtain an exemption (i.e. “waive”) from particular Medicaid statutes.
- The three categories of federal Medicaid waivers are:
 - Section 1115: Research and Demonstration Projects
(e.g. Bridge to Healthcare Reform)
 - Section 1915 (b): Managed Care/Freedom of Choice Waivers
(e.g. Specialty Mental Health Consolidation Program)
 - Section 1915 (c): Home and Community-Based Services Waivers
(e.g. A Pediatric Palliative Care)

Medi-Cal Indian Health Clinic Data



Indian Health Clinic Medi-Cal Providers

- 63 primary care clinic sites serving American Indian/Alaskan Native
 - 6 Tribal Federally Qualified Health Centers (FQHC) sites
 - 49 Indian Health Services Memorandum of Agreement (IHS/MOA)
 - 8 Urban Indian FQHC Clinics sites



Number of Med-Cal Visits by Age at Indian Health Clinics (includes Duplicate Users) July 2010 – March 2012

July 2010 - May 2011 (11 months)

Age Group	Users	Visits	# Visit per Users
0-20	26,797	75,600	2.82
21-64	33,656	54,180	1.61
65 or older	3,800	6,118	1.61
Total All Ages	64,253	135,898	2.12
Total 21 years and over	37,456	60,298	1.61

July 2011 - March 2012 (9 months)

Age Group	Users	Visits	# Visit per Users
0-20	29,471	38,711	1.31
21-64	35,269	49,335	1.40
65 or older	3,938	5,003	1.27
Total All Ages	68,678	93,049	1.35
Total 21 years and over	39,207	54,338	1.39

Source: DHCS-Research and Analytical Studies Branch. Fee-For-Service, DHCS Administered, Medi-Cal '35' file paid claims data. User, visit, and expenditure totals do not include claims with clinical classifications of "disorders of teeth and jaw" – ccs_prime '136.'

Note: Data represent incomplete counts. Totals included less than a twelve-month lag.

Number of Registered Indians* and Paid Claims Per Quarter for IHS/HCFA (CMS) MOA Clinics Calendar Year (CY) 2010 and 2011 (All Age Groups – includes Duplicate Users)

CY 2010

CY 2011

QUARTERLY	NUMBER OF INDIAN MATCH	TOTAL AMOUNT PAID	\$289/VISIT
JAN 2010 - MAR 2010	16,506	\$3,914,841	13,546
APR 2010 - JUN 2010	16,076	\$3,874,376	13,406
JULY 2010 - SEPT 2010	12,374	\$2,784,214	9,634
OCT 2010 - DEC 2010	24,795	\$5,985,799	20,712
TOTAL		\$16,559,230	57,298

QUARTERLY	NUMBER OF INDIAN MATCH	TOTAL AMOUNT PAID	\$294/VISIT
JAN 2011 - MAR 2011	109,342	\$5,785,381	19,678
APR 2011 - JUN 2011	20,118	\$5,121,724	17,421
JULY 2011 - SEPT 2011	16,818	\$4,423,114	15,045
OCT 2011 - DEC 2011	16,598	\$4,464,430	15,185
TOTAL		\$19,794,649	67,329

Based on data received from the Federal Indian Health Services, California Rural Indian Health Board, Inc., and Redding Rancheria data match.

*Indian defined as any member of a federally recognized Indian tribe; any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant is living in California, is a member of the Indian community served by a local program of the Indian Health Service, and is regarded as an Indian by the community in which such descendant lives; any Indian who holds trust interest in public domain, national forest, or Indian reservation allotments in California; any Indian in California who is listed on the plans for distribution of the assets of California Rancherias and reservations under the Indian Self Determination Act (Public Law 93-638)

Number of Indian Health Clinic Visits per Unduplicated User Ages 21 and Older July 2010 – March 2012

July 2010 – June 2011 (12 months)

- Users 13,240
- Visits 59,474
- Range 1 to 83
- Mean 4.50
- Median 3
- Mode 1
- 10,963 of 13,240 had 7 or less visits

July 2011 – March 2012 (9 months)

- Users 15,064
- Visits 54,338
- Range 1 to 85
- Mean 3.61
- Median 2
- Mode 1
- 13,491 of 15,064 had 7 or less visits

Indian Health Clinic Payments

Fiscal Year (FY) 2009-2010 and 2010-2011

FY 2009-2010

- Tribal Indian Health Clinics (FQHC & MOA)
 - Paid \$42 million
 - Average \$3.5 million per month
- Urban Indian Health Clinics
 - Paid \$10 million
 - Average \$832 thousand per month

FY 2010-2011

- Tribal Indian Health Clinics (FQHC & MOA)
 - Paid \$48 million
 - Average \$4 million per month
- Urban Indian Health Clinics
 - Paid \$13 million
 - Average \$1 million per month

Indian Health Clinic Utilization by Top Fifteen Clinical Classifications Categories by Expenditures (All Ages) July 2011 – March 2012

Number	Clinical Classification Category	Users	Visits	Expenditures
1	Disorders of teeth and jaw	25,002	55,895	\$16,473,459
2	Administrative/social admission	5,770	9,114	\$2,462,052
3	Spondylosis; intervertebral disc disorders; other	2,369	5,151	\$1,287,513
4	Other upper respiratory infections	3,578	4,507	\$1,193,671
5	Mood disorders	1,866	4,650	\$1,140,164
6	Normal pregnancy and/or delivery	938	3,656	\$966,140
7	Anxiety disorders	1,044	2,328	\$606,499
8	Residual codes; unclassified	1,789	2,224	\$594,973
9	Other non-traumatic joint disorders	1,550	2,241	\$561,418
10	Attention-deficit conduct and disruptive behavior	693	1,995	\$560,040
11	Immunizations and screening for infectious disease	2,101	2,330	\$557,214
12	Diabetes mellitus without complication	1,492	2,581	\$557,071
13	Medical examination/evaluation	1,958	2,015	\$528,214
14	Essential hypertension	1,358	2,114	\$429,177
15	Other connective tissue disease	1,163	1,689	\$415,856

Source. Fee-for-Service, DHCS administered, Medi-Cal '35' file paid claims data, July 2011 – March 2012 months of payment. Data represent incomplete counts (1-9 months of claim lag).

Calculations do not include Presumptive Eligibles or Family PACT (aid codes '7F', '7G', '8H') as eligibility and enrollment for these programs are determined by providers and is not available in the Medi-Cal enrollment files (MEDS).

Tribal Medi-Cal Administrative Activities (MAA)

- The Tribal MAA program reimburses Tribes and Tribal Organizations for performing administrative activities allowed by the Tribal MAA program including, Outreach, Facilitating Medi-Cal Application Referrals to Medi-Cal Services, Non-Emergency/Non-Medical Transportation, Program and Policy Development, and MAA Claims Coordination
- Currently 18 participating providers
- Over \$1 million in paid claims since 2010.



DHCS Update



State Fiscal Year 2011-2012 Cost Containment Proposals

- Rate Reductions – Imposes 10 percent payment reductions to physicians, clinics, optometrists, therapists, dentists, hospital outpatient departments, medical transportation, durable medical equipment, and clinical laboratories per Welfare and Institutions (W & I) Code, Section 14105.192
 - Update: Proposal approved by CMS on October 27, 2011. However, a series of court cases have challenged the proposed rate reductions. These cases remain on appeal with the 9th Circuit Court with hearings scheduled for July or August. DHCS is currently enjoined from implementing the reductions as of January 31, 2012
- 7 Visit Soft Cap – proposed a limit of seven office visits per beneficiary, per year as authorized by W & I Code, Section 14131.07. For purposes of this limit, a visit includes physician services provided at any FQHC, RHC, community clinic, outpatient clinic, and hospital outpatient department.
 - Update: This proposal is still pending CMS review and approval

State Fiscal Year 2011-2012

Cost Containment Proposals (cont.)

- Adult Day Health Center Services Elimination – approved by CMS on July 21, 2011
 - Update: Replaced by the Community-Based Adult Services (CBAS) program as a result of litigation settlement. CBAS will provide medical and social services to individuals with health care needs as of April 1, 2012
- Beneficiary Copayments –DHCS submitted an amendment to the 1115 Bridge to Reform Demonstration Waiver, which would allow the State to impose mandatory copayments on Medi-Cal beneficiaries
 - Update: This proposal was rejected by CMS in February 2012.

Other Affordable Care Act Activities

- Provider Preventable Conditions Implementation

Update: SPA 12-008 was submitted to CMS on April 5, and it is currently under review by CMS. It is hoped that the SPA will be approved within 90 days from when it was submitted so that DHCS can implement by July 2012

- Medi-Cal Beneficiaries Smoking Cessation Program

Update: The Medi-Cal Incentives to Quit project is currently in a pilot phase in Sacramento County. Data is being collected on the effect of the incentive (\$20 gift card) on call volume to the California Smokers' Helpline as well as effective outreach strategies. The plan is currently to ramp up statewide in July. Early indications show that the availability of the incentive is working – call volume to the Helpline from Sacramento County has doubled since the incentive became available

Other Affordable Care Act Activities (cont.)

- Continued Work on Establishing the Health Benefits Exchange (HBEX)
Update: The HBEX has scheduled a meeting on July 6, 2012 in Sacramento to provide an opportunity for Tribal and HBEX officials to discuss the unique issues and concerns of Tribes regarding the work of the HBEX and the implementation of the federal Affordable Care Act. For more information on this meeting or the HBEX please contact:

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California Health Benefit Exchange
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1115 Bridge to Health Care Reform Waiver Program

- California Children's Services Demonstration Projects
 - The pilot projects are aimed at improving health outcomes, cost-effectiveness, creating clearer accountability, improving satisfaction with care, and promoting timely access to family centered care
 - Grant awards made to entities in San Mateo, Alameda, Orange, Los Angeles, and San Diego counties
- Low Income Health Program (LIHP)
 - Covers adults between 19 and 64 years of age with family incomes at or below 200% of federal poverty level
 - Fourteen entities (13 counties and County Medical Services Program (CMSP)) have implemented LIHP
 - Indian Health Clinics in LIHP
 - 38 IHCs sites contracted with CMSP (CMSP provide services to LIHP enrollees). CMSP have 34 participating counties
 - 6 IHCs sites contracted in LIHP (Los Angeles County (1), Santa Clara County (1), and San Diego County (4)).

The Medi-Cal Budget Proposals Update FY 2012-2013



California State Budget Process Overview

- Governor Released proposed fiscal year 2012-2013 budget in January 10, 2012
 - Anticipated \$9.2 billion deficit
 - <http://www.ebudget.ca.gov/pdf/BudgetSummary/HealthandHumanServices.pdf>
- Legislature holds budget hearings
- Governor Releases “May Revise” budget in May with updated economic data
 - Anticipates \$15.7 billion deficit
 - <http://www.ebudget.ca.gov/pdf/Revised/BudgetSummary/HealthandHumanServices.pdf>

Creation of Office of Health Equity

- Consolidate DHCS' Office of Women's Health, Department of Public Health (DPH) Office of Multicultural Health, Health in All Policies Task Force, the Health Places Team, and Department of Mental Health (DMH) Office of Multicultural Services into the new Office of Health Equity (OHE) within DPH.

Update:

- Senate Subcommittee #3: Held open on April 12, 2012
- Assembly Budget Subcommittee #1: Held open on March 26, 2012
- Final vote will be part of May Revise agenda

Require Annual Open Enrollment Periods for Medi-Cal Enrollees

- Annual open enrollment will provide beneficiaries the opportunity to select their Medi-Cal health plan each year and receive care through that health plan for the entire year.

Update:

- Senate Subcommittee #3: Reject, Vote 3-0 on April 26, 2012
- Assembly Budget Subcommittee #1: Reject, Vote 4-0 on April 30, 2012
- This proposal remains in the May Revision of the FY 2012-2013 budget

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Payment Reform

- Reform the payment methodology for FQHCs and RHCs to create a performance, risk-based payment model that will allow, and reward clinics for providing more efficient and better care
- Payments made to FQHCs and RHCs participating in Medi-Cal managed care plan contracts would change from a cost-and volume-based payment to a fixed payment to provide a broad range of services to its enrollees
- A waiver of current operating restrictions would empower FQHCs to follow efficient best practices, such as group visits, telehealth, and telephonic disease management.

Update:

- Senate Subcommittee #3: Reject, Vote 2-1 on April 26, 2012
- Assembly Subcommittee # 1: Reject, Vote 4-0 on April 30, 2012
- This proposal remains in the May Revision of the FY 2012-2013 budget

Expand Managed Care to Rural Counties

- Expand Managed Care into rural counties beginning in June 2012
- Currently, Managed Care Plans are in 30 of the 58 counties in California.

Update:

Adopt Trailer Bill language to expand Managed Care to 28 rural counties beginning June 2013 and require DHCS to engage with stakeholders

- Senate Subcommittee # 3: Reject, Vote 2-0 on May 17, 2012
- Assembly Budget Subcommittee #1: Held open on April 30, 2012
- Final vote will be part of May Revise agenda

Coordinated Care Initiative

Promote Coordinated Care: The budget proposes to improve care coordination for dual eligible beneficiaries by transitioning them to managed care phased in over a three-year period starting January 1, 2013

- Transition to managed care for Medi-Cal benefits will occur in the first year, with the benefits becoming a more integrated managed care plan responsibility over the subsequent two years.
- Transition of Medicare benefits to managed care will occur over a three-year period starting first with eight to ten counties that already have the capacity to coordinate care for these individuals
- Beneficiaries in counties in which Medi-Cal managed care plans may not yet have the capacity to take on additional beneficiaries will begin to transition six or twelve months later

Note: The Budget separately proposes to expand Medi-Cal managed care statewide starting in June 2013. Beneficiaries in these managed care expansion counties will transition in 2014-15.

Update:

The May Revision proposes to move the implementation date from January 1, 2013 to March 1, 2013. Enrollment will be phased in throughout 2013. The number of counties proposed for demonstration implementation in 2013 has been reduced from ten to eight. The May Revision limits dual eligible mandatory enrollment in Medi-Cal managed care in 2013 to only eight counties.

- Senate Subcommittee #3: Held open on May 21, 2012
- Final vote will be part of May Revise agenda

Transfer of Departments of Alcohol and Drug Programs (ADP) & Mental Health (DMH) Programs

- Eliminate both DMH and ADP
- This proposal reorganizes behavioral health programs. With the elimination of the DMH and the ADP, major community mental health programs and remaining non-Drug Medi-Cal programs and associated funding will be shifted
- Remaining non-health related functions would be transferred to various Departments such as licensing to the Department of Social Services.

Update:

- Senate Subcommittee #3: Held open on April 12, 2012
- Final vote will be part of May Revise agenda

Transfer of Medical Services from DPH

- Transfer of Medical Service Programs from DPH to DHCS:
 - Every Women Counts
 - Prostate Cancer Treatment
 - Family Planning, Access, Care and Treatment (FPACT)
- The transfer of these programs is consistent with the Administration's goal of placing direct health care service programs with DHCS to improve service delivery.

Update:

- Senate Subcommittee #3: Approve, Vote 3-0 on May 10, 2012
- Final vote will be part of May Revise agenda

Healthy Families Program to Med-Cal

- Healthy Families Program would transition to DHCS as part of the broader Medi-Cal program beginning in October 2012
- Reduce payments to Healthy Families managed care plans by 25.7% effective October 2012
- Eliminate MRMIB effective 7/1/13
 - This proposal eliminates MRMIB and transfers its programs and responsibilities to DHCS in preparation for California's implementation of federal health care reform
 - Programs proposed to transfer to DHCS: Access for Infants and Mothers, County Children's Health Initiative Program, Major Risk Medical Insurance Program, Pre-Existing Conditions Insurance Plan, and Healthy Families Program.

Update:

- Senate Subcommittee #3: Reject, Vote 2-1 on May 21, 2012
- Assembly Budget Subcommittee #1: Held open on April 30, 2012
- Final vote will be part of May Revise agenda

Medical Therapy Program Means Test

- The Medical Therapy Program (MTP) is a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have handicapping conditions, generally due to neurological or musculoskeletal disorders
- Implement income eligibility requirements, or means testing, for the California Children's Services (CCS) Medical Therapy Program. Currently, there is no financial test for eligibility
- The proposed means test is consistent with the eligibility requirements already in place for all other CCS benefits.

Update:

- Senate hearing scheduled in May
- Assembly Budget Subcommittee #1: Held open on April 30, 2012
- Final vote will be part of May Revise agenda

Other DHCS Budget Proposals

- Eliminates the sunset date of the Gross Premiums Tax on Medi-Cal managed care plans

Update:

- Senate Subcommittee #3: Reject, Vote 2-1 on May 21, 2012
 - Assembly Budget Subcommittee #1: Held open on April 30, 2012
 - Final vote will be part of May Revise agenda
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- A one-time redirection of private and non-designated public hospital stabilization funding that has not yet been paid for fiscal years 2005-06 through 2009-10 to provide General Fund savings and avoid direct service reductions.

Update:

- Senate Subcommittee #3: Approve on April 26, 2012
- Assembly Budget Subcommittee #1: Held open on April 30, 2012
- Final vote will be part of May Revise agenda

Other DHCS Budget Proposals (cont.)

- Extends for two years the sunset date for the rate methodology and nursing home fee initially established by AB 1629

Update:

- Senate Subcommittee #3: Held open on March 22, 2012
 - Assembly Budget Subcommittee #1: Approve, Vote 5-0 on April 30, 2012
 - Final vote will be part of May Revise agenda
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- Proposes a value-based purchasing process that will incorporate stakeholder input and determine cost-effectiveness before implementing changes in benefit design, and includes a post-implementation assessment to assure that changes achieve the intended results.

Update:

- Senate Subcommittee #3: Held open on March 22, 2012
- Assembly Budget Subcommittee #1: Held open on April 30, 2012
- Final vote will be part of May Revise agenda

New Proposals

- Hospital Payment Changes – Reduce supplemental payments to private hospitals, eliminate public hospital grants, and eliminate increases to managed care plans for supplemental payments to designated public hospitals
- Nursing Homes – Rescind the 2.4 percent rate increase for nursing homes and set aside 1 percent of nursing home payments for supplemental payments based on quality measures
- Implementing Copayments – Copayments of \$15 for non-emergency room visits and \$1 and \$3 copayments for pharmacy based on the drug status and how medications are dispensed to achieve savings of \$20.2 million General Fund.

Advisory Process

- Designees:
 - 28 of 39 Indian health clinics updated their designees in September
 - In the absence of a designee, DHCS directs communications to the clinic Executive Director
- Tribal Chairpersons:
 - DHCS completed an update of all Tribal Chairperson in May 2012
- Next Quarterly Webinar – May 30, 2012 from 2-3 p.m. To register contact Elva Galindo at 916-449-5767 or by email at elva.galindo@dhcs.ca.gov
- DHCS Proposed SPA 12-002 Update to Tribal Advisory Process
 - Will clarify situations where DHCS is required to notify Tribes, designees of Indian health programs concerning proposed changes to Medi-Cal program; will clarify what situations allow for an expedited notification process; and proposes to modify the schedule for sending notices and invitations
 - Update: DHCS received comments from CMS and responded. SPA 12-002 is pending approval. Once approved DHCS will distribute the final approved version.

THANK YOU

