

Department of Health Care Services (DHCS) Indian Health Services Program Directors Meeting



June 19, 2012

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



Yosemite Falls

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, includes Duplicate Users) July 2011 – April 2012

Tribal Clinics				
#	Clinical Classification Category	Users	Visits	Expenditures
1	Disorders of teeth and jaw	22,118	22,485	\$15,324,852
2	Administrative/social admission	4,237	4,257	\$2,196,288
3	Spondylosis; intervertebral disc disorders; other	2,207	2,230	\$1,333,048
4	Other upper respiratory infections	3,285	3,291	\$1,189,863
5	Mood disorders	1,627	1,654	\$1,064,846
6	Normal pregnancy and/or delivery	709	767	\$736,344
7	Residual codes; unclassified	1,829	1,836	\$637,392
8	Attention-deficit conduct and disruptive behavior	682	702	\$603,724
9	Anxiety disorders	961	969	\$602,320
10	Other non-traumatic joint disorders	1,461	1,467	\$562,565
11	Diabetes mellitus without complication	1,243	1,254	\$511,531
12	Medical examination/evaluation	1,781	1,783	\$508,998
13	Otitis media and related conditions	1,114	1,118	\$438,639
14	Other connective tissue disease	1,048	1,053	\$402,278
15	Immunizations and screening for infectious disease	1,190	1,193	\$362,704
Urban Clinics				
#	Clinical Classification Category	Users	Visits	Expenditures
1	Disorders of teeth and jaw	4,929	4,929	\$3,230,307
2	Administrative/social admission	2,013	2,013	\$578,054
3	Normal pregnancy and/or delivery	328	329	\$559,948
4	Immunizations and screening for infectious disease	1,032	1,032	\$232,956
5	Mood disorders	385	385	\$218,355
6	Contraceptive and procreative management	405	405	\$184,621
7	Other upper respiratory infections	694	694	\$169,082
8	Diabetes mellitus with complications	359	359	\$158,305
9	Essential hypertension	448	448	\$146,644
10	Spondylosis; intervertebral disc disorders; other	392	392	\$137,885
11	Invalid diagnosis	32	37	\$117,966
12	Diabetes mellitus without complication	343	343	\$110,076
13	Other screening for suspected conditions (not ment	407	407	\$88,633
14	Medical examination/evaluation	395	395	\$83,443
15	Anxiety disorders	186	186	\$83,179

Source. Fee-for-Service, DHCS administered, Medi-Cal '35' file paid claims data, July 2011 – April 2012 months of service. Data are considered incomplete as July 2011 through April 2012 have 0-9 months of updates.

Tribal and Urban Indian Health Clinics Expenditures for Disorders of Teeth and Jaw (includes Duplicate Users) July 2009 through April 2012

July 2009 – June 2010

Users: 25,451

Visits: 26,008

Expenditures: \$19,188,940

July 2010 – June 2011

Users: 31,146

Visits: 31,726

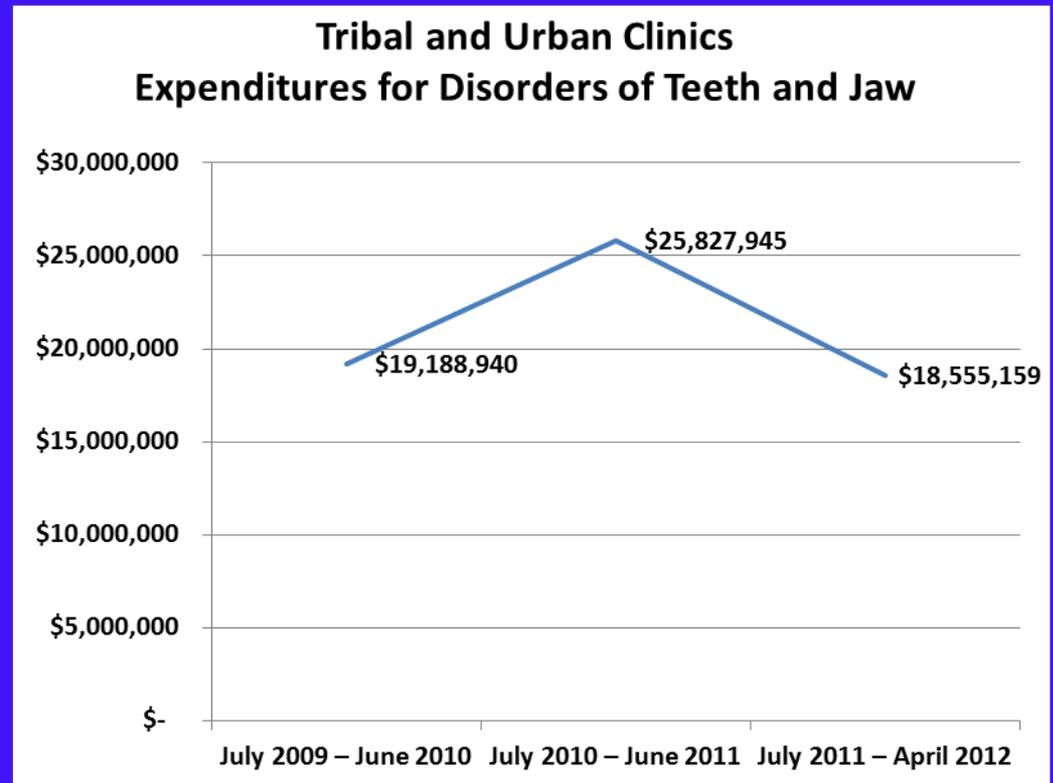
Expenditures: \$25,827,945

July 2011 – April 2012

Users: 27,047

Visits: 27,414

Expenditures: \$18,555,159



Source. Fee-for-Service, DHCS administered, Medi-Cal '35' file paid claims data, July 2009 – March 2012 months of service. May 2011 – April 2012 data are considered incomplete as they don't have 12 months of updates.

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 Indian Health Clinics

Expenditures for Disorders of Teeth and Jaw (includes Duplicate Users) July 2009 through April 2012

July 2009 – June 2010

Users: 21,473

Visits: 22,028

Expenditures: \$16,132,347

July 2010 – June 2011

Users: 25,178

Visits: 25,756

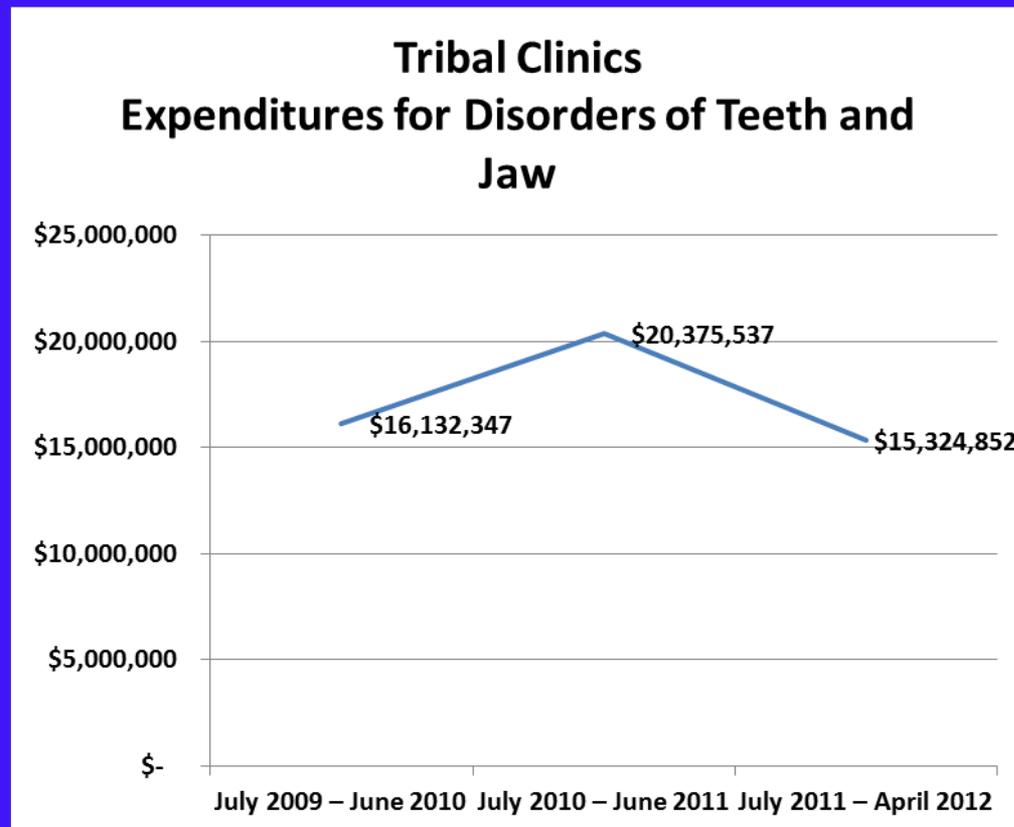
Expenditures: \$20,375,537

July 2011 – April 2012

Users: 22,118

Visits: 22,485

Expenditures: \$15,324,852



Source: Fee-for-Service, DHCS administered, Medi-Cal '35' file paid claims data, July 2009 – March 2012 months of service. May 2011 – April 2012 data are considered incomplete as they don't have 12 months of updates.

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



Lassen Peak

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 outcome decision

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.

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

- 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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Affordable Care Act Activities (cont.)

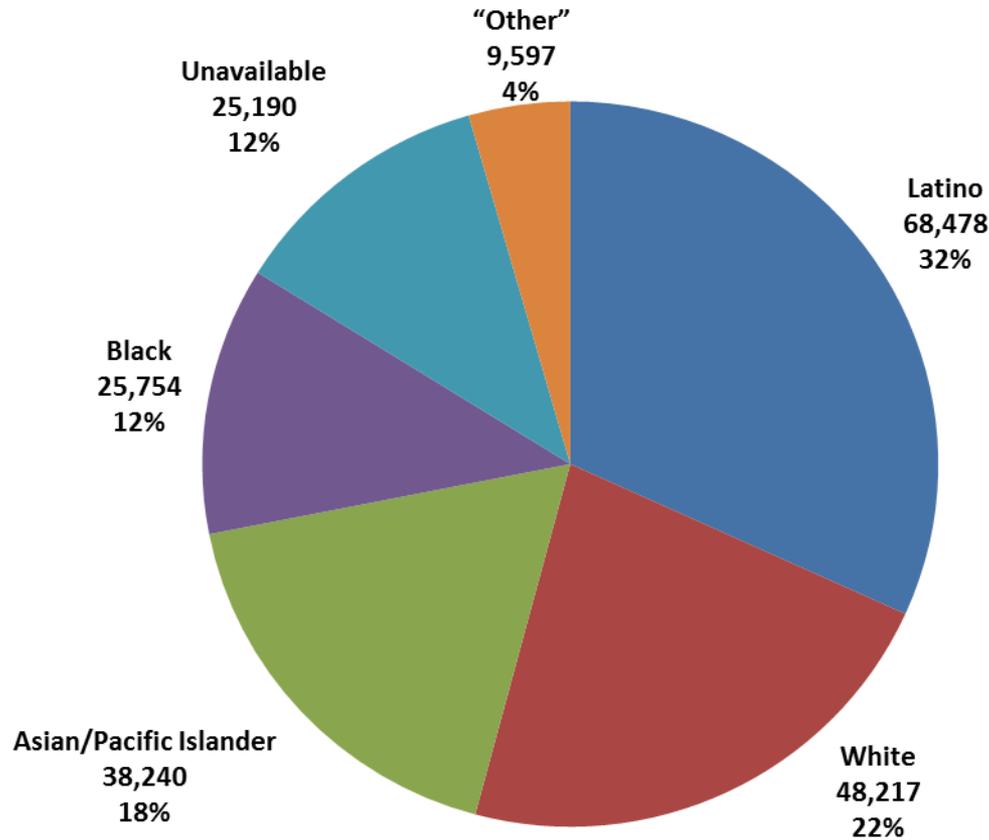
- **Medi-Cal Incentives to Quit Smoking (MIQS) Project**
 - Purpose
 - To test the use of incentives in Medicaid to change population health
 - Target populations with high chronic disease prevalence (diabetes and heart disease) and high smoking prevalence per California Health Interview Survey
 - \$10 million/5-year award from the Centers for Medicare and Medicaid Services
 - Project period is September 2011 to September 2016
 - Project incentive is a \$20 gift card to a major retailer after Medi-Cal members call the California Smokers' Helpline and ask for the incentive, complete the intake call, and complete the first session with a counselor
 - The Helpline will test various other incentives:
 - Nicotine Replacement Therapy (NRT)
 - Retention incentives
 - Re-engagement incentives
 - Eligibility
 - All Medi-Cal members who smoke are eligible for the \$20 gift card
 - Smokers with co-occurring chronic disease will be eligible for the additional NRT or retention incentives.

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 (363,871 enrollees in March 2012)
 - 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)).

LIHP Enrollees by Race/Ethnicity

**LIHP Enrollees by Race/Ethnicity
December 2011**



There are 215,476 LIHP enrollees in December 2011.
American Indian/Alaskan Natives are in "Other" category.

The Medi-Cal Budget Proposals Update FY 2012-2013



Kings Canyon National Park, California

California State Budget Process Overview

- Governor introduces proposed budget on January 10th of every year
 - Anticipate \$9.2 billion deficit in FY 2012-13
 - <http://www.ebudget.ca.gov/pdf/BudgetSummary/HealthandHumanServices.pdf>
- Legislature holds budget hearings
- Governor releases “May Revise” budget in May with updated economic data
 - Anticipate \$15.7 billion deficit in FY 2012-13
 - <http://www.ebudget.ca.gov/pdf/Revised/BudgetSummary/HealthandHumanServices.pdf>
- Governor and Legislature negotiate final budget and Budget Trailer Bill
- Governor signs Final Budget and Budget Trailer Bill

Budget Proposal

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: Approved; in Budget for Governor Review

- Senate Subcommittee #3: Approve, Vote 2-1 on May 24, 2012 with Trailer Bill Language (TBL)
- Assembly Budget Subcommittee #1: Approve, Vote 3-1 on May 31, 2012 with TBL

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: Denied; Not in Budget for Governor Review

- Senate Subcommittee #3: Reject, Vote 3-0 on April 26, 2012
- Assembly Budget Subcommittee #1: Reject, Vote 4-0 on April 30, 2012

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: Denied; Not in Budget for Governor Review

- Senate Subcommittee #3: Reject, Vote 2-1 on April 26, 2012
- Assembly Subcommittee # 1: Reject, Vote 4-0 on April 30, 2012

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: Approved; in Budget for Governor Review

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

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
- California’s Demonstration to Integrate Care for Dual Eligible Individuals proposal (the demonstration) requires beneficiaries to remain enrolled in that same plan for six-month stable enrollment period during which health plans must ensure continuity of care. Beneficiaries would be able maintain relationships with their out-of-network Medicare providers for up to six months upon enrollment and out-of-network Medi-Cal providers for up to twelve months.
- Dual eligible Indian Medi-Cal members enrolled in the demonstration will not be subject to the six month stable enrollment period requirement and may opt-out of the demonstration at any time.
- The demonstration is a key component of the larger CCI and should it be approved DHCS will issue further notifications to tribes and designees. More information can be found at <http://calduals.org/>

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: Approved; in Budget for Governor Review

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.

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: Approved DMH; in Budget for Governor Review. Denied ADP; Not in Budget for Governor Review.

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: Approved; in Budget for Governor Review

- Senate Subcommittee #3: Approve, Vote 3-0 on May 10, 2012
- Assembly Budget Subcommittee #1: Approve, Vote 4-0 on May 31, 2012 with TBL.

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

Update: Denied provider rate reduction; Not in Budget for Governor Review. Approved transitioning of children whose family income is below 133 percent of the federal poverty level consistent with ACA; in Budget for Governor Review.

- Senate Subcommittee #3: Reject, Vote 2-1 on May 21, 2012
- Assembly Budget Subcommittee #1: Reject, Vote 3-0 on May 24, 2012

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: Denied; Not in Budget for Governor Review

— Senate Subcommittee #3: Reject, Vote 2-0 on May 24, 2012

— Assembly Budget Subcommittee #1: Reject, Vote 3-0 on May 31, 2012

Other DHCS Budget Proposals

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

Update: Approved two year sunset extension; in Budget for Governor Review

- Senate Subcommittee #3: Reject, Vote 2-1 on May 21, 2012
- Assembly Budget Subcommittee #1: Reject on May 31, 2012 – Adopt TBL that extends GPT for 2 years

- 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: Approved; in Budget for Governor Review

- Senate Subcommittee #3: Approve on April 26, 2012
- Assembly Budget Subcommittee #1: Approve on May 31, 2012

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: Approved two year sunset extension; in Budget for Governor Review

- Senate Subcommittee #3: Reject on May 24, 2012 – Approve TBL to extend for 2 years
 - Assembly Budget Subcommittee #1: Reject on May 31, 2012 – Approve TBL to extend for 2 years
- 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: Denied; Not in Budget for Governor Review

- Senate Subcommittee #3: Reject, Vote 3-0 on May 24, 2012
- Assembly Budget Subcommittee #1: Reject, Vote 4-0 on May 31, 2012

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

Update:

- Senate Subcommittee #3: Held open on May 24, 2012
 - Assembly Budget Subcommittee #1: Held open on May 23, 2012
- 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

Update:

- Senate Subcommittee #3: Held open on May 24, 2012
 - Assembly Budget Subcommittee #1: Held open on May 31, 2012
- 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.

Update: Approved; in Budget for Governor Review

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
- DHCS Proposed SPA 12-002 which Update the Tribal/Designee Advisory Process Clarifies situations where DHCS is required to notify Tribes, designees of Indian health programs concerning proposed changes to Medi-Cal program; clarifies 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 was approved on June 15. DHCS will distribute and post on the IHP website.
- DHCS currently working with Health and Human Services Agency and the Governor's Tribal Liaison to develop a Tribal Consultation policy consistent with the Executive Order B-10-11.



THANK YOU