

EVERY WOMAN COUNTS

**November 2011
Estimate Package**

2012-13 GOVERNOR'S BUDGET



**Ron Chapman, MD, MPH
Director**

**CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH**

Table of Contents

<u>SECTION</u>	<u>PAGE</u>
1. Fiscal Comparison Tables	3
2. Program Background	6
3. Future Fiscal Issues and Major Assumptions	6
<u>Future Fiscal Issues</u>	6
A. Low Income Health Program (California Bridge to Reform 1115 Waiver for Medi-Cal Eligibility) – Impact of full implementation of the “Non-Legacy” LIHP County Programs on EWC	
B. Digital Mammography	7
Table 2: Mammogram Comparison Rates	7
C. Single Point Enrollment/Identity	8
<u>Major Assumptions</u>	9
A. Low Income Health Program (California Bridge to Reform 1115 Waiver for Medi-Cal Eligibility) – Impact of the Ten “Legacy” LIHP Counties on EWC	
Table 3: LIHP FPL% Eligibility Maximums	10
<u>Revised Major Assumptions</u>	11
<u>Discontinued Major Assumptions</u>	11
4. Funding and Expenditure History	12
Figure 1: Total Funds by Fiscal Year	13
Figure 2: Fiscal Year Budgeted Amounts by Category	14
5. Fund Condition Statement: Breast Cancer Control Account Fund 0009	15
Table 4: Fund Condition Statement	15
6. Projection Methodology	16
<u>Cost Estimates Using Percent Change Model</u>	16
A. Clinical Claims Costs	16
B. Low Income Health Program (California Bridge to Reform 1115 Waiver for Medi-Cal Eligibility) – Impact of the Ten “Legacy” LIHP Counties on EWC	17
7. Caseload	19
Two Methods of Caseload Calculations	19
Table 5: Projected Caseload	20
A. Ten Percent Medi-Cal Reduction to Clinical Services	21
8. Acronyms	22

Table 1

1. Fiscal Comparison Tables (in thousands)

EWC Activity	Table 1a: Expenditure Comparison: FY 2011-12 Revised Estimate to FY 2011-12 Budget Act														
	2011-12 in 2012-13 Revised Estimate						2011-12 Budget Act						Difference		
	Total	0236	0009	FF	GF	Total	0236	0009	FF	GF	Total	0236	0009	FF	GF
Clinical Services															
Office Visits and Consults	12,374	5,669	2,402	1,124	3,179	14,720	4,549	1,922	918	7,331	-2,346	1,120	480	206	-4,152
Screening Mammograms	14,849	6,777	2,873	1,337	3,862	19,365	5,984	2,528	1,208	9,645	-4,516	793	345	129	-5,783
Diagnostic Mammograms	4,712	2,239	941	468	1,064	5,861	1,811	766	366	2,918	-1,149	428	175	102	-1,854
Diagnostic Breast Procedures	5,901	2,771	1,168	569	1,393	7,431	2,296	970	464	3,701	-1,530	475	198	105	-2,308
Case Management	3,665	1,770	741	377	777	15,434	4,769	2,015	963	7,687	-11,769	-2,999	-1,274	-586	-6,910
Other Clinical Services	6,092	2,855	1,205	584	1,448	8,648	2,672	1,129	540	4,307	-2,556	183	76	44	-2,859
Subtotal Service Categories	47,593	22,081	9,330	4,459	11,723	71,459	22,081	9,330	4,459	35,589	-23,866	0	0	0	-23,866
LHP (1115 Waiver)	-2,898	0	0	0	-2,898	0	0	0	0	0	-2,898	0	0	0	-2,898
Clinical Services including LHP	44,695	22,081	9,330	4,459	8,825	71,459	22,081	9,330	4,459	35,589	-26,764				-26,764
10% Medi-Cal Reduction for Clinical Services	-4,470	0	0	0	-4,470	-7,145	0	0	0	-7,145	2,675	0	0	0	2,675
Tiered-Case Management (\$50/\$0) *	0	0	0	0	0	-9,183	0	0	0	-9,183	9,183	0	0	0	9,183
Medi-Cal Rate Reduction/Radiology *	0	0	0	0	0	-840	0	0	0	-840	840	0	0	0	840
Total Clinical Services	40,225	22,081	9,330	4,459	4,355	54,291	22,081	9,330	4,459	18,421	-14,066	0	0	0	-14,066
Local Assistance Contracts	3,544	0	3,544	0	0	3,544	0	3,544	0	0	0	0	0	0	0
Total Local Assistance Appropriation	43,769	22,081	12,874	4,459	4,355	57,835	22,081	12,874	4,459	18,421	-14,066	0	0	0	-14,066
EWC State Operations Budget															
Fiscal Intermediary - Processing Costs	1,251	0	1,251	0	0	500	0	500	0	0	751	0	751	0	0
Fiscal Intermediary - System Development Notices	0	0	0	0	0	500	0	500	0	0	-500	0	-500	0	0
Other EWC Support Costs	6,252	0	3,758	2,494	0	6,532	0	4,038	2,494	0	-280	0	-280	0	0
Total State Operations Expense	7,503	0	5,009	2,494	0	7,532	0	5,038	2,494	0	-29	0	-29	0	0

* 2011-12 in 2012-13 Revised Estimate - Cost Savings for Tiered-Case Management and Medi-Cal Rate Reductions/Radiology as shown in 2011-12 Budget Act were included in the projections for each service category and not calculated separately.

1. Fiscal Comparison Tables (in thousands)

Table 1b: Expenditure Comparison: FY 2012-13 to FY 2011-12 Budget Act															
EWC Activity	2012-13 Estimate				2011-12 Budget Act				Difference						
	Total	0236	0009	FF	GF	Total	0236	0009	FF	GF	Total	0236	0009	FF	GF
Clinical Services															
Office Visits and Consults	13,611	5,830	786	1,142	5,853	14,720	4,549	1,922	918	7,331	1,237	161	-1,616	18	2,674
Screening Mammograms	16,334	6,990	934	1,364	7,046	19,365	5,984	2,528	1,208	9,645	1,485	213	-1,939	27	3,184
Diagnostic Mammograms	5,183	2,236	327	454	2,166	5,861	1,811	766	366	2,918	471	-3	-614	-14	1,102
Diagnostic Breast Procedures	6,491	2,795	398	561	2,737	7,431	2,296	970	464	3,701	590	24	-770	-8	1,344
Case Management	4,031	1,345	263	360	2,063	15,434	4,769	2,015	963	7,687	366	-425	-478	-17	1,286
Other Clinical Services	6,701	2,885	409	578	2,829	8,648	2,672	1,129	540	4,307	609	30	-796	-6	1,381
Subtotal Service Categories	52,351	22,081	3,117	4,459	22,694	71,459	22,081	9,330	4,459	35,589	4,758	0	-6,213	0	10,971
LHP (1115 Waiver)	-7,600	0	0	0	-7,600	0	0	0	0	0	-4,702	0	0	0	-4,702
Clinical Services including LHP	44,751	22,081	3,117	4,459	15,094	71,459	22,081	9,330	4,459	35,589	56	0	-6,213	0	6,269
10% Medi-Cal Reduction for Clinical Services	-4,475	0	0	0	-4,475	-7,145	0	0	0	-7,145	-5	0	0	0	-5
Tiered-Case Management (\$50/\$30) *	0	0	0	0	0	-9,183	0	0	0	-9,183	0	0	0	0	0
Medi-Cal Rate Reduction/Radiology *	0	0	0	0	0	-940	0	0	0	-940	0	0	0	0	0
Total Clinical Services	40,276	22,081	3,117	4,459	10,619	54,291	22,081	9,330	4,459	18,421	51	0	-6,213	0	6,264
Local Assistance Contracts	3,544	0	3,544	0	0	3,544	0	3,544	0	0	0	0	0	0	0
Total Local Assistance Appropriation	43,820	22,081	6,661	4,459	10,619	57,835	22,081	12,874	4,459	18,421	51	0	-6,213	0	6,264
EWC State Operations Budget															
Fiscal Intermediary - Processing Costs	1,251	0	1,251	0	0	500	0	500	0	0	0	0	0	0	0
Fiscal Intermediary - System Development Notices	0	0	0	0	0	500	0	500	0	0	0	0	0	0	0
Other EWC Support Costs	5,783	0	3,289	2,494	0	6,532	0	4,038	2,494	0	-469	0	-469	0	0
Total State Operations Expense	7,034	0	4,540	2,494	0	7,532	0	5,038	2,494	0	-469	0	-469	0	0

* 2012-13 Estimate - Cost savings as shown in 2011-12 Budget Act were included in the projections for each service category and not calculated separately.

**2012-13 EWC Activity is proposed to transfer to DHCS July 1, 2012.

1. Fiscal Comparison Tables (in thousands)

Table 1c: Expenditure Comparison: 2012-13 Estimated to 2011-12 in 2012-13 Revised Estimate															
EWC Activity	2012-13 Estimate				2011-12 in 2012-13 Revised Estimate				Difference						
	Total	0236	0009	FF	GF	Total	0236	0009	FF	GF	Total	0236	0009	FF	GF
Clinical Services															
Office Visits and Consults	13,611	5,830	786	1,142	5,853	12,374	5,669	2,402	1,124	3,179	1,237	161	-1,616	18	2,674
Screening Mammograms	16,334	6,990	934	1,364	7,046	14,849	6,777	2,873	1,337	3,862	1,485	213	-1,939	27	3,184
Diagnostic Mammograms	5,183	2,236	327	454	2,166	4,712	2,239	941	468	1,064	471	-3	-614	-14	1,102
Diagnostic Breast P procedures	6,491	2,795	398	561	2,737	5,901	2,771	1,168	569	1,393	590	24	-770	-8	1,344
Case Management	4,031	1,345	283	360	2,063	3,665	1,770	741	377	777	366	-425	-478	-17	1,286
Other Clinical Services	6,701	2,885	409	578	2,829	6,092	2,855	1,205	594	1,448	609	30	-796	-6	1,381
Subtotal Service Categories	52,351	22,081	3,117	4,459	22,694	47,593	22,081	9,330	4,459	11,723	4,758	0	-6,213	0	10,971
LHP (1115 Waiver)	-7,600	0	0	0	-7,600	-2,898	0	0	0	-2,898	-4,702	0	0	0	-4,702
Clinical Services including LHP	44,751	22,081	3,117	4,459	15,094	44,695	22,081	9,330	4,459	8,825	56	0	-6,213	0	6,269
*10% Medi-Cal Reduction for Clinical Services	-4,475	0	0	0	-4,475	-4,470	0	0	0	-4,470	-5	0	0	0	-5
Tiered-Case Management (\$50/\$0) *	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medi-Cal Rate Reduction/Radiology *	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Clinical Services	40,276	22,081	3,117	4,459	10,619	40,225	22,081	9,330	4,459	4,355	51	0	-6,213	0	6,264
Local Assistance Contracts	3,544	0	3,544	0	0	3,544	0	3,544	0	0	0	0	0	0	0
Total Local Assistance Appropriation	43,820	22,081	6,661	4,459	10,619	43,769	22,081	12,874	4,459	4,355	51	0	-6,213	0	6,264
EWC State Operations Budget															
Fiscal Intermediary - Processing Costs	1,251	0	1,251	0	0	1,251	0	1,251	0	0	0	0	0	0	0
Fiscal Intermediary - System Development Notices	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other EWC Support Costs	5,783	0	3,289	2,494	0	6,252	0	3,757	2,494	0	-468	0	-468	0	0
Total State Operations Expense	7,034	0	4,540	2,494	0	7,503	0	5,008	2,494	0	-468	0	-468	0	0

* 2012-13 Estimate - Cost savings as shown in 2011-12 Budget Act were included in the projections for each service category and not calculated separately.

**2012-13 EWC Activity is proposed to transfer to DHCS July 1, 2012.

2. Program Background

PROGRAM BACKGROUND

The mission of the California Department of Public Health (CDPH) Cancer Detection Section (CDS) is to save lives by preventing and reducing the devastating effects of cancer on Californians through early detection, diagnostic, and treatment services. With services focusing on low-income, uninsured, and underserved women, the Every Woman Counts (EWC) Program offers multi-faceted, early detection and diagnostic services for breast and cervical cancer, coupled with continuous monitoring to reduce missed or delayed cancer diagnosis. The EWC Program serves 20 percent of eligible uninsured and underinsured women age 40 and older in California.

The EWC Program is a quality improvement and outcome-driven public health program that serves to raise the accessibility and quality of cancer screening and diagnostic services for low-income underserved women. The EWC Program provides support services to recruit and maintain screening in the underserved populations of African-American, Asian-Pacific Islander, and American Indian women as well as older and rural women.

As of July 1, 2012, the EWC Program, including expenditure and position authority, is proposed to transfer to the Department of Health Care Services (DHCS). This shift will allow both DHCS and CDPH to focus more closely on their core missions, goals, and objectives. Please see Budget Change Proposal EX-02 Transfer of Direct Service Programs to Department of Health Care Services for more information.

3. Future Fiscal Issues and Major Assumptions

FUTURE FISCAL ISSUES

A. Impact of full implementation of the “Non-Legacy” Low Income Health Program County Programs on EWC

California was granted a Medicaid 1115 waiver that allows counties to receive federal funds to support Low Income Health Programs (LIHP) administered through DHCS. While LIHP is a voluntary program at the county level, it is anticipated that most counties will implement LIHPs with proposed implementation dates during Fiscal Year (FY) 2011-12. DHCS has a goal of full implementation statewide by January 2012. The first counties to implement LIHP

will be the ten who participated in the LIHP demonstration that have capacity to enroll new eligible clients into LIHP. Those counties are called “Legacy-LIHPs”. Caseload and fiscal estimates associated with the implementation of those ten LIHPs with respect to EWC are discussed in Major Assumptions, number A. - page 8.

To the extent that the remaining LIHPs (non-legacy) are implemented during FY 2011-12, there will be a fiscal impact to EWC. The magnitude of the impact to the EWC Program and savings is unknown at this point due to the many uncertainties currently surrounding the LIHP implementation, including: when the non-legacy LIHPs will implement, at what income levels eligibility will be based, the impact of LIHP enrollment caps and how many EWC women will transition to LIHP.

B. Digital Mammography

The EWC program will experience increased costs in FY 2013-14 due to the sunset date (January 1, 2014) of Assembly Bill (AB) 359 (Revenue and Taxation Code: Section 30461-30462.1, Chapter 435). AB 359 requires EWC to reimburse for digital mammography (DM) screening at the lower Medi-Cal reimbursement rate for analog (film) mammography (AM). This policy allows EWC providers to offer DM (and be paid the prevailing AM rate) when AM services are not available. On January 1, 2014, the DPH will be required to reimburse for DM at the higher Medi-Cal DM rate. A portion of mammography screening will continue to be AM (where DM is not available) and paid at the AM rate, but that portion is expected to decrease over time as more providers move to provide DM screening. Unless the sunset date is extended or eliminated from statute, the EWC Program will experience increased clinical claims costs. See table below for a comparison of the rates:

Table 2

Mammogram	Analog Rate*	Digital Rate*	Difference
Screening (both breasts)	\$72.16	\$127.24	\$55.08
Diagnostic (both breasts)	\$85.80	\$132.97	\$47.17
Diagnostic (one breast)	\$68.76	\$107.57	\$38.81

*As of 8/11/11 per Medi-Cal website

C. Single Point of Enrollment/Identity

A Single Point of Enrollment/Identity (SPI) will address findings from the Bureau of State Audits Report 2010-103 dated June 2010. These findings state DPH does not have the mechanism to determine true caseload for the EWC Program and should provide for a centrally managed enrollment process for eligible women to increase accuracy of projections and reporting of the number of women served.

Identity and enrollment data would be collected and processed at a single, central location. EWC providers would confirm the woman's eligibility and certify the enrollment found in the EWC data reporting system, DETecting Early Cancer (DETEC). SPI will strengthen probabilistic matching and there by improve DPH's ability to ensure women are enrolled only once into the program which would increase the accuracy of caseload projections.

SPI requires programming to make the appropriate system change. In FY 2010-11, CDS sent a System Development Notice (SDN) to the DHCS fiscal intermediary (FI) contractor to begin the process of a system change for a SPI for women enrolling in the EWC Program. DHCS and Hewlett Packard, the previous FI, estimated the costs for the SDN at approximately \$725,000. However, any changes to the costs for programming and the timetable for completion will be unknown until the new Medi-Cal FI has an opportunity to evaluate the SDN. DHCS informed CDS of a moratorium on system changes during the new FI takeover period. The new FI will review and prioritize all existing SDNs in the queue after January 2012.

One approach to implementation of SPI is to utilize the contract for the EWC Consumer 800 Number. If this approach is feasible with the FI, women would call the Consumer 800 Number in order to enroll in the EWC Program. The 800 Number contractor would therefore experience higher call volumes and longer calls to accommodate this change. CDS will continue to analyze this SPI approach for fiscal implications.

Another approach to implementing SPI would be to adjust the enrollment algorithm in DETEC in which additional controls would be applied to women identified as potential duplicates. In this case, control of enrollment would reside in DPH. Both approaches would require an SDN.

MAJOR ASSUMPTIONS

A. Impact of the Ten “Legacy” LIHP Counties on EWC

Women who are served by the EWC Program with income at or below 200 percent of the Federal Poverty Level (FPL) may be eligible for the new LIHP 1115 Waiver in their county.

On November 2, 2010, the State received federal approval of its five-year 1115(a) Medicaid Demonstration waiver entitled, “California’s Bridge to Reform.” This waiver will advance Medi-Cal program changes that will help the State transition to the federal health care reforms that will take effect in January 2014. Included as one of these changes, LIHP will phase in health coverage for adults ages 19-64 years with incomes up to 200 percent of the federal poverty level (FPL), as determined by each county, who are not otherwise eligible for Medicaid. While the program is voluntary at the county level, it is anticipated that most counties will implement LIHPs. The first ten counties to implement LIHP, referred to collectively as the “Legacy” counties, include Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. These ten counties represent the 27.2 percent of all eligible EWC clients (based on the 2009 California Health Interview Survey) enrolled in LIHP who may be covered by the EWC Program). LIHP will end on December 31, 2013 as health care reform is implemented.

By October 1, 2011, all ten contracts for the Legacy counties were approved between DHCS and the Legacy counties but they are pending final approval from the federal Centers for Medicare and Medicaid Services (CMS). The remaining counties (“non-Legacy”) are in earlier stages of developing their LIHPs thus program information was not available prior to the submission of this estimate. Please refer to Future Fiscal Issue, number A, page 6 for a discussion of the non-Legacy counties.

LIHP consists of two optional components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). For both components, eligible individuals must be between 19 and 64 years of age, may not be otherwise eligible for Medicaid, must be non-pregnant, must meet income eligibility standards of the respective county, must meet the county residency requirement and must be legally residing in the United States. In addition:

- MCE – Individuals must have family incomes at or below 133 percent of FPL (based on participating county standards). MCE is not subject to a cap on federal funding and has a broader range of services than that of

HCCI. Each county can set the income eligibility at or anywhere below 133 percent of the FPL. An individual with private insurance is eligible for MCE as long as the family income meets the county's income eligibility requirement.

- HCCI – Individuals must have family incomes from 134-200 percent of FPL, and no third-party coverage. HCCI offers a narrower range of services than MCE and is subject to a cap on federal funding. Each county can set their FPL between 134 percent and 200 percent. The county must have an MCE program in place with an FPL of 133 percent in order to be eligible for an HCCI program. Individuals with private insurance are not eligible for HCCI.

Additional features that are left to the discretion of the county include:

- Enrollment caps – if a county determines that it will exceed available funding it can establish a cap first for its HCCI program then for its MCE program.
- Waiting lists – may be initiated if an enrollment cap is in effect and a six-month outreach plan is in place to notify those on the waiting list of their coverage opportunities.

EWC clients who are eligible and choose to transition to LIHP will result in reduced EWC expenditures. The amount of reduced expenditures is contingent on the many issues previously noted, including each county's implementation timing, income eligibility criteria, and program features.

To determine the impact of LIHP on the EWC Program for FYs 2011-12 and 2012-13, DPH will first determine the number of women age 40 to 64 who are potential LIHP-eligible clients, based on the table below of counties enrolling clients into LIHP. DPH will then estimate the initial unadjusted impacts of shifting these clients into LIHP, and finally will calculate the number of EWC women who will potentially move to LIHP.

Table 3

LIHP FPL% ELIGIBILITY MAXIMUMS FOR THE 10 LEGACY COUNTIES		
LEGACY COUNTY	MCE FPL%	HCCI FPL%
Alameda	133%	200%
Contra Costa	133%	200%
Kern	100%	*
Los Angeles	133%	*

Orange	133%	200%
San Diego	133%	*
San Francisco	25%	*
San Mateo	133%	*
Santa Clara	75%	*
Ventura	133%	200%

*HCCI program not implemented in this county.

REVISED MAJOR ASSUMPTIONS

The EWC program was closed to new enrollments and did not serve women age 40-49 from January 1, 2010 to November 30, 2010. Therefore, DPH did not use the above months to project costs for FY 2011-12 and FY 2012-13.

The DPH used the same methodology as described in the 2011 May Revise Estimate, but changed the time period used to calculate and project clinical claims costs. DPH used the periods when program was serving age 40 and over for breast cancer and open to new enrollment. In addition, DPH utilized the time period that captures the reduced case management costs which started on July 1, 2010.

After the policy changes in calendar year 2010, the EWC Program experienced slower than expected resumption of enrollments. Therefore, clinical claims have not materialized to the degree anticipated in FY 2010-11. DPH has evaluated the fiscal impact to the General Fund (GF) appropriation, and adjusted the projected expenditures and caseload for FY2011-12 and FY2012-13.

DISCONTINUED MAJOR ASSUMPTIONS

There are no Discontinued Major Assumptions to report at this time.

4. Funding and Expenditure History

The EWC program is funded by four funding sources. The first, Proposition 99 Unallocated (Prop 99), is a tobacco tax based fund. Due to a decreasing incidence of smoking, Prop 99 funds are a slowly declining yet still sizable source of revenue. From a high of \$30.8 million in FY 2006-07, funding for the program from this fund fell to \$22.1 million in FY 2009-10. Prop 99 funding for FY 2011-12 remains static at \$22.1 million.

The second funding source is the Breast Cancer Control Account (BCCA). The BCCA is funded by a two cent tobacco tax. The EWC Program receives one cent of the tax for the BCCA with the other one cent going to the Breast Cancer Research Account. The BCCA is anticipated to slowly decline due to less tobacco use. In May 2011, DPH was notified there was an unexpended balance in the Breast Cancer Fund and \$2.2 million would be transferred to the BCCA. This one-time funding will be used to pay clinical claims and will offset GF expenditures. FY 2011-12 Local Assistance funding from BCCA is \$12.9 million.

The third source of funding is federal funding from the Center for Disease Control and Prevention (CDC). Funding from the CDC began in 1990 and has continued into FY 2011-12. The program, known as the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), offers funding to programs for cervical and breast cancer outreach, education and early detection and quality clinical services. FY 2011-12 Local Assistance funding from NBCCEDP is \$4.5 million.

The fourth source of funding is GF. For FY 2011-12, the GF is offset by \$2.2 million as a result of the one-time increase in BCCA. The total GF appropriation for FY 2011-12 is \$18.4 million. See Figure 1 for total funds by Fiscal Year.

The 2011-12 state operations budget for the EWC Program is \$5 million from BCCA and \$2.5 million from NBCCEDP.

The EWC Program's budget for FY 2011-12 estimates that the DPH will spend approximately 85 percent of total funds on local assistance contracts and clinical claims for the EWC Program. See Figure 2.

Figure 1

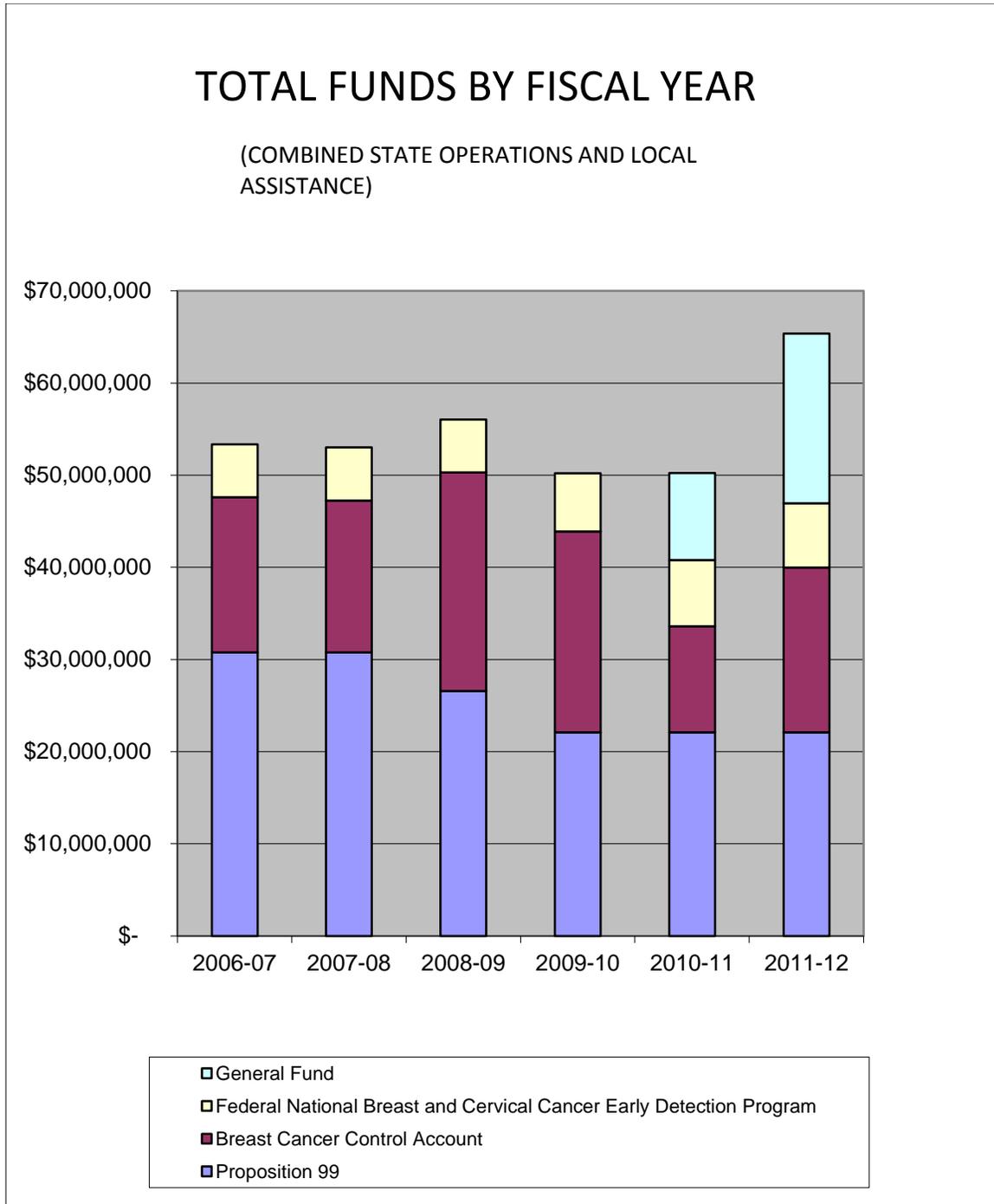
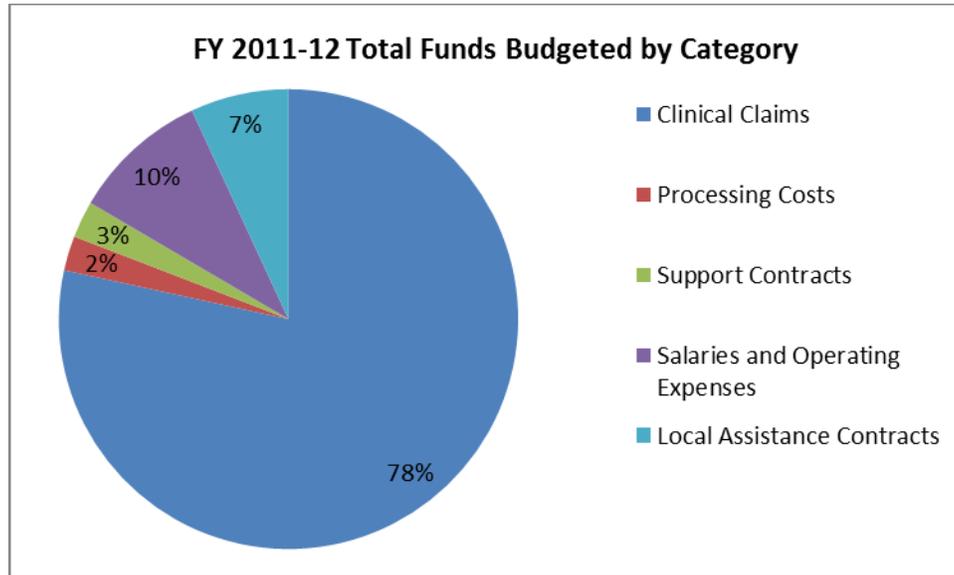


Figure 2



Note: Total funds include the Breast Cancer Control Account, Prop 99, Federal National Breast and Cervical Cancer Early Detection Program, and the General Fund.

5. Fund Condition Statement Breast Cancer Control Account Fund 0009

Table 4

Fund 0009 - Breast Cancer Control Account	2010-11	2011-12	2012-13
BEGINNING BALANCE	5,468	8,896	1,888
Prior Year Adjustment	671		
ADJUSTED BEGINNING BALANCE	6,139	8,896	1,888
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS			
Revenues			
150300 Income From Surplus Money Investments	50	50	50
Total Revenues	50	50	50
Transfers and Other Adjustments			
FO0004 From Breast Cancer Fund per Revenue and Taxation Code Section 30461.6	13,137	10,965	10,640
Total Transfers and Other Adjustments	13,137	10,965	10,640
TOTAL RESOURCES	19,326	19,911	12,578
EXPENDITURES AND EXPENDITURE ADJUSTMENTS			
Expenditures			
0840 State Controller (State Operations)	51	29	23
4260 Department of Health Care Services			
State Operations	6	112	4,633
Local Assistance	0	0	6,661
4265 Department of Public Health			
State Operations	4,152	5,008	0
Local Assistance	6,216	12,874	0
8880 Financial Information System for California (State Operations)	5		
TOTAL EXPENDITURES	10,430	18,023	11,317
FUND BALANCE	8,896	1,888	1,261

6. Projection Methodology

The DPH's ability to forecast costs and caseload is reduced due to the interruption in the clinical services from January 1, 2010 through November 30, 2010, when women age 40 to 49 were ineligible to receive breast cancer screening services, and the program implemented a moratorium on new enrollments. Therefore, assumptions and projections are based on the same methodology, but include the following limitations:

Costs

- To calculate percent change, the time period when the program was not serving women ages 40-49 nor open to new enrollments was excluded.
- To perform trend analysis, DPH used available preliminary claims data on the first ten months of actual claims paid (since the program re-opened for new enrollments).

Caseload

- Caseload must be determined retrospectively, as there is no single point of enrollment.
- The rate of new enrollments since DPH resumed clinical services to women age 40 and older is yet to be determined, as we do not yet have a full year of data.
- The time series regression model is limited to data through December 2009, which is prior to being closed to new enrollments.

DPH uses actual cost data with adjustments as needed when calculating cost and caseload projections.

COST ESTIMATES USING PERCENT CHANGE MODEL

A. Clinical Claims Costs

As a base, DPH used the actual paid clinical claims costs for the following periods of time:

- July 1, 2008 - December 31, 2009
- February 1, 2011 – July 30, 2011

These periods of time capture claims costs when the EWC Program was serving women age 40 and over and allowing new enrollments into the program. DPH

did not use the period of January 2010 through November 2010 when the program was neither allowing services for women ages 40-49 nor allowing new enrollments. In addition, the period of December 2010 and January 2011 was not used, because claims volume was low during these months, while women resumed accessing services after the program restarted, and to allow for the lag time between when women receive services and DPH is billed for the expense.

Using the percent change model, the annual rate of growth was ten percent using the time periods above. Ten percent was used to project costs into Current Year (CY) 2011-12 in the amount of \$47.6 million.

In addition, DPH performed a trend analysis of costs in the first ten months (December 2010 through September 2011) after the program opened to new enrollments. This analysis projects a ten percent increase in costs for both CY 2011-12 and Budget Year (BY) 2012-13.

To project clinical claims costs for BY 2012-13, DPH used the estimated annual increase of ten percent. This is due to the fact that DPH expects to see a gradual increase in enrollment of eligible women into the program. DPH will continue to monitor clinical claims costs and may make changes to the projections during the May Revise budget process if the change is more or less than ten percent. The estimated projected clinical claims cost for BY 2012-13 is \$44.8 million.

The projected clinical claims cost is broken down by service category in Tables 1a, 1b, and 1c (pages 3-5).

- Projected clinical claims costs for BY 2012-13: \$44.8 million.

B. Impact of the Ten “Legacy” LIHP Counties on the EWC Program

DPH used the California Health Interview Survey (2009 data) for the ten legacy counties to derive the estimated proportions of LIHP enrollees who may be eligible for the EWC Program. The enrollees are estimated separately for MCE and HCCI and the methodology is calculated as follows:

- MCE – Based on family income between 0-133 percent - Women (ages 40-64) who are uninsured/total number of people (all ages) insured and uninsured.
- HCCI – Based on family income between 134-200 percent - Women (ages 40-64) who are uninsured/total number of uninsured people (all ages).

Based on the LIHP August Monthly Enrollment sheet, released by DHCS dated 10/17/2011, the LIHP enrollment for FY 2011-12 is 196,471 (MCE - 175,519 and HCCI – 20,952,895 and 10.5 percent respectively). From the total LIHP enrollments, approximately 20,700 EWC women could shift to LIHP in FY 2011-12.

The total LIHP enrollment is estimated to be 500,000 by December 2013 (MCE – 446,500 and HCCI – 52,500), assuming the distribution of MCE and HCCI is the same as FY 2011-12. From the total of 303,529 estimated new LIHP enrollments in FY 2012-13, approximately 32,000 EWC women could shift to LIHP in FY 2012-13, for a potential shift of 52,700 women in two years.

DPH then applied the annual cost per woman to the EWC LIHP caseload shift to determine the amount of savings. The cost per woman does not include the ten percent reduction in Medi-Cal rates.

FY 2011-12 the savings due to LIHP is estimated at \$2.8 million (20,700 women times \$139.98).

FY 2012-13 the savings due to LIHP is estimated at \$7.6 million (52,700 women times \$144.22).

7. Caseload

DPH defines caseload as the number of unique women who receive at least one paid service during the fiscal year.

As there is uncertainty in the number of EWC unique women due to a lack of single point of enrollment, two methods were used to project caseload: 1) Average Cost Method and 2) Time Series Regression Method.

In the first method, caseload was determined by using the projected annual clinical claims cost for FY 2012-13 of \$44.8 million and dividing it by the expected average cost per woman.

DPH calculated the expected average cost per woman by:

1. Starting with the FY 2010-11 average cost per woman without case management costs.
2. Applying a three percent increase to allow for periodic Medi-Cal rate changes.
3. Adding a \$50 case management fee for the estimated 20 percent of the caseload that is eligible (based on abnormal results of screening procedures).

The projected caseload using this method for FY 2012-13 is 363,000.

In the final step the potential shift of 52,700 women into the LIHP was subtracted for a projected caseload in FY 2012-13 of 310,000 (see Table 5, page 20).

Table 5

Fiscal Year	Calculated Caseload	Months Serving All Women	Calculated Caseload if Serving All Women for 12 Months
	Actual		
2006-07	244,500 ¹	12	244,500 ¹
2007-08	256,700 ¹	12	256,700 ¹
2008-09	283,600 ¹	12	283,600 ¹
2009-10	235,000 ²	6	300,000
2010-11	217,600 ³	7	311,000
Projected			
2011-12	319,000	12	319,000 ⁴
2012-13	310,000	12	310,000 ⁴
¹ Serving women 40+ no cost saving policies in place ² 6 months no new enrollments, no women 40-49 ³ 5 months no new enrollments, no women 40-49 7 months new enrollments, women 40+, reduction in mammography rates, tiered case management ⁴ New enrollments, women 40+, reduction in mammography rates, tiered case management, LIHP, and 10% reduction in Medi-Cal rates.			

In the second method, DPH calculated the caseload using a time-series regression model based on the number of unique women served at least once between January 1, 2006 and December 31, 2009 (48 months). The 95 percent upper confidence level for the caseload using this method is 366,000.

After subtracting for the potential shift of 52,700 women to LIHP the projected caseload is 313,000.

- Based on the above two methods, the projected caseload for FY 2012-13 is 310,000 using average cost method or up to 313,000 using the time series regression method.

A. Ten Percent Medi-Cal Reduction to Clinical Services

Chapter 3, Statutes of 2011 includes a ten percent rate reduction to Medi-Cal fee-for-service benefits. Because the program reimburses EWC providers at Medi-Cal rates, this change will result in clinical claims savings to the program.

- Projected savings to clinical claims costs from the BY 2012-13 ten percent Medi-Cal reduction is \$4.5 million.

8. Acronyms

AB – *Assembly Bill*

ACL - Adjudicated Claim Line

AM – Analog Mammography

BCCA – *Breast Cancer Control Account*. This is Cancer Detection Program (CDP): EWC's portion of a two-cent tobacco tax. The BCCA receives one cent of this tax. It is a declining fund source.

BY – *Budget Year*

CDC – Center for Disease Control and Prevention

CDPH – *California Department of Public Health*. The Department which oversees the CDP: EWC program.

CDS – *Cancer Detection Section*. The Section of the CDPH which is responsible for the CDP: EWC program.

CMS – Centers for Medicare/Medicaid Services

CY – *Current Year*

DETEC – *DETECTing EARLY Cancer*. A centralized reporting system providers use to submit data.

DHCS – *California Department of Health Care Services*. This is the department responsible for processing CDP: EWC clinical claims.

DM – Digital Mammography

EWC –Every Woman Counts

FI – Fiscal Intermediary

Film - Analog

FLP – Federal Poverty Level

FY – *Fiscal Year*

GF – General Fund

HCCI – Health Care Coverage Initiative

LIHP – Low Income Health Program

MCE – Medicaid Coverage Expansion

NBCCEDP – *National Breast and Cervical Cancer Early Detection Program*. This is the federally funded portion of the *CDP: EWC* program.

Prop 99 – Proposition 99 Unallocated. Tobacco tax based fund.

SDN – System Development Notice

SPI – Single Point of Enrollment/Identity