MEDI-CAL
MAY 2010
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2009-10 and 2010-11

BASE
POLICY CHANGES

Fiscal Forecasting and Data Management Branch
State Department of Health Care Services
1501 Capitol Avenue, Suite 6069
Sacramento, CA 95814
(916) 552-8550

ARNOLD SCHWARZENEGGER
Governor
State of California

S. Kimberly Belshé
Secretary
California Health and Human Services Agency

David Maxwell-Jolly
Director
Department of Health Care Services

Medi-Cal Base Policy Changes

The Medi-Cal base estimate consists of projections of expenditures based on recent trends of actual data. The base estimate does not include the impact of future program changes, which are added to the base estimate through regular policy changes as displayed in the Regular Policy Change section.

The base estimate consists of two types. The first type, the Fee-for-Service Base Estimate, is described and summarized in the previous section (FFS Base).

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is displayed in this section. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. As a result, this second type of base estimate will be called Base Policy Changes because as in the past they are entered into the Medi-Cal Estimate and displayed using the policy change format. These Base Policy Changes form the base estimates for the last 12 service categories (Managed Care through Recoveries) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

Base Policy Change Service Categories:
Two Plan Model
County Organized Health Systems
Geographic Managed Care
PHP & Other Managed Care (Other M/C)
Dental
Mental Health
Audits/Lawsuits
EPSDT Screens
Medicare Payments
State Hospital/Developmental Centers
Miscellaneous Services (Misc. Svcs.)
Recoveries

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2009-10

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	MANAGED CARE			
54	TWO PLAN MODEL	$4,014,207,000	$2,008,916,700	$2,005,290,300
55	COUNTY ORGANIZED HEALTH SYSTEMS	$2,523,491,000	$1,267,067,100	$1,256,423,900
56	GEOGRAPHIC MANAGED CARE	$687,588,000	$344,135,800	$343,452,200
59	PACE (Other M/C)	$124,460,000	$62,230,000	$62,230,000
60	DENTAL MANAGED CARE (Other M/C)	$48,225,000	$24,112,500	$24,112,500
63	SENIOR CARE ACTION NETWORK (Other M/C)	$27,966,000	$13,983,000	$13,983,000
66	AIDS HEALTHCARE CENTERS (Other M/C)	$8,905,000	$4,452,500	$4,452,500
68	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$2,869,000	$1,434,500	$1,434,500
69	PHP	$2,604,000	$1,300,100	$1,303,900
	MANAGED CARE SUBTOTAL	**$7,440,315,000**	**$3,727,632,200**	**$3,712,682,800**
	OTHER			
123	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,205,311,000	$3,205,311,000	$0
124	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,284,989,000	$1,074,787,000	$1,210,202,000
125	MENTAL HEALTH SERVICES-CDMH	$1,247,729,000	$1,247,729,000	$0
126	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,312,104,000	$0	$1,312,104,000
127	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	$1,243,687,000	$1,243,687,000	$0
128	DENTAL SERVICES	$553,103,000	$276,551,500	$276,551,500
129	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$319,561,000	$319,561,000	$0
130	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$207,131,000	$207,131,000	$0
131	MENTAL HEALTH DRUG MEDI-CAL-CDADP	$119,484,000	$119,484,000	$0
134	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	$60,581,000	$60,581,000	$0
135	EPSDT SCREENS	$58,891,000	$29,445,500	$29,445,500
136	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$31,767,000	$15,883,500	$15,883,500
140	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$5,288,000	$2,644,000	$2,644,000
141	LAWSUITS/CLAIMS	$2,516,000	$1,258,000	$1,258,000
143	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,020,000	$1,020,000	$0
151	AUDIT SETTLEMENTS	$0	$0	$0
159	BASE RECOVERIES	-$218,944,000	-$92,087,500	-$126,856,500
	OTHER SUBTOTAL	**$10,434,218,000**	**$7,712,986,000**	**$2,721,232,000**
	GRAND TOTAL	**$17,874,533,000**	**$11,440,618,200**	**$6,433,914,800**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2010-11

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	MANAGED CARE			
54	TWO PLAN MODEL	$4,313,642,000	$2,151,541,200	$2,162,100,800
55	COUNTY ORGANIZED HEALTH SYSTEMS	$2,870,268,000	$1,437,126,200	$1,433,141,800
56	GEOGRAPHIC MANAGED CARE	$760,759,000	$379,800,150	$380,958,850
59	PACE (Other M/C)	$146,335,000	$73,167,500	$73,167,500
60	DENTAL MANAGED CARE (Other M/C)	$51,847,000	$25,923,500	$25,923,500
63	SENIOR CARE ACTION NETWORK (Other M/C)	$45,727,000	$22,970,500	$22,756,500
66	AIDS HEALTHCARE CENTERS (Other M/C)	$11,300,000	$5,674,500	$5,625,500
68	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,217,000	$1,608,500	$1,608,500
69	PHP	$1,932,000	$965,100	$966,900
	MANAGED CARE SUBTOTAL	**$8,205,027,000**	**$4,098,777,150**	**$4,106,249,850**
	OTHER			
123	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,392,863,000	$3,392,863,000	$0
124	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,583,989,000	$1,212,523,000	$1,371,466,000
125	MENTAL HEALTH SERVICES-CDMH	$1,606,979,000	$1,606,979,000	$0
126	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,376,469,000	$0	$1,376,469,000
127	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	$1,064,485,000	$1,064,485,000	$0
128	DENTAL SERVICES	$562,636,000	$281,318,000	$281,318,000
129	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$273,220,000	$273,220,000	$0
130	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$152,331,000	$152,331,000	$0
131	MENTAL HEALTH DRUG MEDI-CAL-CDADP	$60,157,000	$60,157,000	$0
134	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	$70,275,000	$70,275,000	$0
135	EPSDT SCREENS	$60,555,000	$30,277,500	$30,277,500
136	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$38,020,000	$19,010,000	$19,010,000
140	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$4,586,000	$2,293,000	$2,293,000
141	LAWSUITS/CLAIMS	$1,865,000	$932,500	$932,500
143	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$1,028,000	$0
151	AUDIT SETTLEMENTS	$0	$0	$0
159	BASE RECOVERIES	-$218,716,000	-$91,992,000	-$126,724,000
	OTHER SUBTOTAL	**$11,030,742,000**	**$8,075,700,000**	**$2,955,042,000**
	GRAND TOTAL	**$19,235,769,000**	**$12,174,477,150**	**$7,061,291,850**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2010 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2009 ESTIMATE
FISCAL YEAR 2009-10

		2009-10 APPROPRIATION		NOV. 2009 EST. FOR 2009-10		MAY 2010 EST. FOR 2009-10		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE										
54	TWO PLAN MODEL	$3,880,075,000	$1,951,076,500	$3,947,046,000	$1,982,869,650	$4,014,207,000	$2,005,290,300	$134,132,000	$54,213,800	$67,161,000	$22,420,650
55	COUNTY ORGANIZED HEALTH SYSTEMS	$2,065,811,000	$1,034,858,000	$2,113,473,000	$1,058,166,800	$2,523,491,000	$1,256,423,900	$457,680,000	$221,565,900	$410,018,000	$198,257,100
56	GEOGRAPHIC MANAGED CARE	$638,277,000	$320,805,000	$663,258,000	$333,186,950	$687,588,000	$343,452,200	$49,311,000	$22,647,200	$24,330,000	$10,265,250
59	PACE (Other M/C)	$152,872,000	$76,436,000	$129,305,000	$64,652,500	$124,460,000	$62,230,000	-$28,412,000	-$14,206,000	-$4,845,000	-$2,422,500
60	DENTAL MANAGED CARE (Other M/C)	$54,695,000	$27,347,500	$58,448,000	$29,224,000	$48,225,000	$24,112,500	-$6,470,000	-$3,235,000	-$10,223,000	-$5,111,500
63	SENIOR CARE ACTION NETWORK (Other M/C)	$39,742,000	$19,871,000	$26,851,000	$13,425,500	$27,966,000	$13,983,000	-$11,776,000	-$5,888,000	$1,115,000	$557,500
66	AIDS HEALTHCARE CENTERS (Other M/C)	$5,085,000	$2,542,500	$8,900,000	$4,450,000	$8,905,000	$4,452,500	$3,820,000	$1,910,000	$5,000	$2,500
68	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,172,000	$1,586,000	$3,474,000	$1,737,000	$2,869,000	$1,434,500	-$303,000	-$151,500	-$605,000	-$302,500
69	PHP	$2,093,000	$1,048,500	$2,473,000	$1,237,950	$2,604,000	$1,303,900	$511,000	$255,400	$131,000	$65,950
	MANAGED CARE SUBTOTAL	**$6,841,822,000**	**$3,435,571,000**	**$6,953,228,000**	**$3,488,950,350**	**$7,440,315,000**	**$3,712,682,800**	**$598,493,000**	**$277,111,800**	**$487,087,000**	**$223,732,450**
	OTHER										
123	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,458,439,000	$0	$3,182,624,000	$0	$3,205,311,000	$0	-$253,128,000	$0	$22,687,000	$0
124	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,273,936,000	$1,199,425,000	$2,312,654,000	$1,224,903,000	$2,284,989,000	$1,210,202,000	$11,053,000	$10,777,000	-$27,665,000	-$14,701,000
125	MENTAL HEALTH SERVICES-CDMH	$1,451,418,000	$0	$1,543,687,000	$0	$1,247,729,000	$0	-$203,689,000	$0	-$295,958,000	$0
126	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,323,826,000	$1,323,826,000	$1,325,823,000	$1,325,823,000	$1,312,104,000	$1,312,104,000	-$11,722,000	-$11,722,000	-$13,719,000	-$13,719,000
127	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	$1,147,206,000	$0	$1,253,194,000	$0	$1,243,687,000	$0	$96,481,000	$0	-$9,507,000	$0
128	DENTAL SERVICES	$681,687,000	$340,843,500	$709,967,000	$354,983,500	$553,103,000	$276,551,500	-$128,584,000	-$64,292,000	-$156,864,000	-$78,432,000
129	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$313,763,000	$0	$275,669,000	$0	$319,561,000	$0	$5,798,000	$0	$43,892,000	$0
130	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$175,959,000	$0	$207,855,000	$0	$207,131,000	$0	$31,172,000	$0	-$724,000	$0
131	MENTAL HEALTH DRUG MEDI-CAL-CDADP	$125,215,000	$0	$122,697,000	$0	$119,484,000	$0	-$5,731,000	$0	-$3,213,000	$0
134	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	$68,486,000	$0	$60,581,000	$0	$60,581,000	$0	-$7,905,000	$0	$0	$0
135	EPSDT SCREENS	$61,433,000	$30,716,500	$58,712,000	$29,356,000	$58,891,000	$29,445,500	-$2,542,000	-$1,271,000	$179,000	$89,500
136	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$33,250,000	$16,625,000	$33,911,000	$16,955,500	$31,767,000	$15,883,500	-$1,483,000	-$741,500	-$2,144,000	-$1,072,000
140	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$7,527,000	$3,763,500	$6,648,000	$3,324,000	$5,288,000	$2,644,000	-$2,239,000	-$1,119,500	-$1,360,000	-$680,000
141	LAWSUITS/CLAIMS	$1,865,000	$932,500	$2,235,000	$1,117,500	$2,516,000	$1,258,000	$651,000	$325,500	$281,000	$140,500
143	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,185,000	$0	$1,020,000	$0	$1,020,000	$0	-$165,000	$0	$0	$0
151	AUDIT SETTLEMENTS	$179,000	$179,000	$0	$0	$0	$0	-$179,000	-$179,000	$0	$0
159	BASE RECOVERIES	-$257,448,000	-$143,398,500	-$242,436,000	-$138,431,000	-$218,944,000	-$126,856,500	$38,504,000	$16,542,000	$23,492,000	$11,574,500

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2010 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2009 ESTIMATE
FISCAL YEAR 2009-10

		2009-10 APPROPRIATION		NOV. 2009 EST. FOR 2009-10		MAY 2010 EST. FOR 2009-10		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER										
	OTHER SUBTOTAL	$10,867,926,000	$2,772,912,500	$10,854,841,000	$2,818,031,500	$10,434,218,000	$2,721,232,000	-$433,708,000	-$51,680,500	-$420,623,000	-$96,799,500
	GRAND TOTAL	$17,709,748,000	$6,208,483,500	$17,808,069,000	$6,306,981,850	$17,874,533,000	$6,433,914,800	$164,785,000	$225,431,300	$66,464,000	$126,932,950

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2010 ESTIMATE COMPARED TO NOVEMBER 2009 ESTIMATE
FISCAL YEAR 2010-11

		NOV. 2009 EST. FOR 2010-11		MAY 2010 EST. FOR 2010-11		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE						
54	TWO PLAN MODEL	$4,052,963,000	$2,036,885,250	$4,313,642,000	$2,162,100,800	$260,679,000	$125,215,550
55	COUNTY ORGANIZED HEALTH SYSTEMS	$2,121,246,000	$1,062,387,650	$2,870,268,000	$1,433,141,800	$749,022,000	$370,754,150
56	GEOGRAPHIC MANAGED CARE	$683,617,000	$343,396,050	$760,759,000	$380,958,850	$77,142,000	$37,562,800
59	PACE (Other M/C)	$156,337,000	$78,168,500	$146,335,000	$73,167,500	-$10,002,000	-$5,001,000
60	DENTAL MANAGED CARE (Other M/C)	$59,507,000	$29,753,500	$51,847,000	$25,923,500	-$7,660,000	-$3,830,000
63	SENIOR CARE ACTION NETWORK (Other M/C)	$44,609,000	$22,304,500	$45,727,000	$22,756,500	$1,118,000	$452,000
66	AIDS HEALTHCARE CENTERS (Other M/C)	$10,988,000	$5,494,000	$11,300,000	$5,625,500	$312,000	$131,500
68	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$3,550,000	$1,775,000	$3,217,000	$1,608,500	-$333,000	-$166,500
69	PHP	$1,784,000	$892,450	$1,932,000	$966,900	$148,000	$74,450
	MANAGED CARE SUBTOTAL	**$7,134,601,000**	**$3,581,056,900**	**$8,205,027,000**	**$4,106,249,850**	**$1,070,426,000**	**$525,192,950**
	OTHER						
123	PERSONAL CARE SERVICES (Misc. Svcs.)	$1,090,671,000	$0	$3,392,863,000	$0	$2,302,192,000	$0
124	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,624,280,000	$1,392,848,500	$2,583,989,000	$1,371,466,000	-$40,291,000	-$21,382,500
125	MENTAL HEALTH SERVICES-CDMH	$975,939,000	$0	$1,606,979,000	$0	$631,040,000	$0
126	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,408,168,000	$1,408,168,000	$1,376,469,000	$1,376,469,000	-$31,699,000	-$31,699,000
127	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	$1,076,675,000	$0	$1,064,485,000	$0	-$12,190,000	$0
128	DENTAL SERVICES	$731,424,000	$365,712,000	$562,636,000	$281,318,000	-$168,788,000	-$84,394,000
129	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$248,304,000	$0	$273,220,000	$0	$24,916,000	$0
130	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$154,930,000	$0	$152,331,000	$0	-$2,599,000	$0
131	MENTAL HEALTH DRUG MEDI-CAL-CDADP	$117,622,000	$0	$60,157,000	$0	-$57,465,000	$0
134	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	$70,275,000	$0	$70,275,000	$0	$0	$0
135	EPSDT SCREENS	$58,719,000	$29,359,500	$60,555,000	$30,277,500	$1,836,000	$918,000
136	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$40,609,000	$20,304,500	$38,020,000	$19,010,000	-$2,589,000	-$1,294,500
140	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$7,197,000	$3,598,500	$4,586,000	$2,293,000	-$2,611,000	-$1,305,500
141	LAWSUITS/CLAIMS	$1,865,000	$932,500	$1,865,000	$932,500	$0	$0
143	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,028,000	$0	$1,028,000	$0	$0	$0
151	AUDIT SETTLEMENTS	$0	$0	$0	$0	$0	$0
159	BASE RECOVERIES	-$249,277,000	-$142,337,000	-$218,716,000	-$126,724,000	$30,561,000	$15,613,000
	OTHER SUBTOTAL	**$8,358,429,000**	**$3,078,586,500**	**$11,030,742,000**	**$2,955,042,000**	**$2,672,313,000**	**-$123,544,500**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2010 ESTIMATE COMPARED TO NOVEMBER 2009 ESTIMATE
FISCAL YEAR 2010-11

		NOV. 2009 EST. FOR 2010-11		MAY 2010 EST. FOR 2010-11		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	GRAND TOTAL	$15,493,030,000	$6,659,643,400	$19,235,769,000	$7,061,291,850	$3,742,739,000	$401,648,450

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2009-10 AND 2010-11

		MAY 2010 EST. FOR 2009-10		MAY 2010 EST. FOR 2010-11		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE						
54	TWO PLAN MODEL	$4,014,207,000	$2,005,290,300	$4,313,642,000	$2,162,100,800	$299,435,000	$156,810,500
55	COUNTY ORGANIZED HEALTH SYSTEMS	$2,523,491,000	$1,256,423,900	$2,870,268,000	$1,433,141,800	$346,777,000	$176,717,900
56	GEOGRAPHIC MANAGED CARE	$687,588,000	$343,452,200	$760,759,000	$380,958,850	$73,171,000	$37,506,650
59	PACE (Other M/C)	$124,460,000	$62,230,000	$146,335,000	$73,167,500	$21,875,000	$10,937,500
60	DENTAL MANAGED CARE (Other M/C)	$48,225,000	$24,112,500	$51,847,000	$25,923,500	$3,622,000	$1,811,000
63	SENIOR CARE ACTION NETWORK (Other M/C)	$27,966,000	$13,983,000	$45,727,000	$22,756,500	$17,761,000	$8,773,500
66	AIDS HEALTHCARE CENTERS (Other M/C)	$8,905,000	$4,452,500	$11,300,000	$5,625,500	$2,395,000	$1,173,000
68	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$2,869,000	$1,434,500	$3,217,000	$1,608,500	$348,000	$174,000
69	PHP	$2,604,000	$1,303,900	$1,932,000	$966,900	-$672,000	-$337,000
	MANAGED CARE SUBTOTAL	**$7,440,315,000**	**$3,712,682,800**	**$8,205,027,000**	**$4,106,249,850**	**$764,712,000**	**$393,567,050**
	OTHER						
123	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,205,311,000	$0	$3,392,863,000	$0	$187,552,000	$0
124	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,284,989,000	$1,210,202,000	$2,583,989,000	$1,371,466,000	$299,000,000	$161,264,000
125	MENTAL HEALTH SERVICES-CDMH	$1,247,729,000	$0	$1,606,979,000	$0	$359,250,000	$0
126	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,312,104,000	$1,312,104,000	$1,376,469,000	$1,376,469,000	$64,365,000	$64,365,000
127	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	$1,243,687,000	$0	$1,064,485,000	$0	-$179,202,000	$0
128	DENTAL SERVICES	$553,103,000	$276,551,500	$562,636,000	$281,318,000	$9,533,000	$4,766,500
129	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$319,561,000	$0	$273,220,000	$0	-$46,341,000	$0
130	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$207,131,000	$0	$152,331,000	$0	-$54,800,000	$0
131	MENTAL HEALTH DRUG MEDI-CAL-CDADP	$119,484,000	$0	$60,157,000	$0	-$59,327,000	$0
134	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	$60,581,000	$0	$70,275,000	$0	$9,694,000	$0
135	EPSDT SCREENS	$58,891,000	$29,445,500	$60,555,000	$30,277,500	$1,664,000	$832,000
136	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$31,767,000	$15,883,500	$38,020,000	$19,010,000	$6,253,000	$3,126,500
140	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$5,288,000	$2,644,000	$4,586,000	$2,293,000	-$702,000	-$351,000
141	LAWSUITS/CLAIMS	$2,516,000	$1,258,000	$1,865,000	$932,500	-$651,000	-$325,500
143	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,020,000	$0	$1,028,000	$0	$8,000	$0
151	AUDIT SETTLEMENTS	$0	$0	$0	$0	$0	$0
159	BASE RECOVERIES	-$218,944,000	-$126,856,500	-$218,716,000	-$126,724,000	$228,000	$132,500

Costs shown include application of payment lag factor, but not percent reflected in base calculation.

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2009-10 AND 2010-11

		MAY 2010 EST. FOR 2009-10		MAY 2010 EST. FOR 2010-11		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
	OTHER SUBTOTAL	$10,434,218,000	$2,721,232,000	$11,030,742,000	$2,955,042,000	$596,524,000	$233,810,000
	GRAND TOTAL	$17,874,533,000	$6,433,914,800	$19,235,769,000	$7,061,291,850	$1,361,236,000	$627,377,050

Costs shown include application of payment lag factor, but not percent reflected in base calculation.

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	MANAGED CARE
54	TWO PLAN MODEL
55	COUNTY ORGANIZED HEALTH SYSTEMS
56	GEOGRAPHIC MANAGED CARE
59	PACE (Other M/C)
60	DENTAL MANAGED CARE (Other M/C)
63	SENIOR CARE ACTION NETWORK (Other M/C)
66	AIDS HEALTHCARE CENTERS (Other M/C)
68	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
69	PHP
	OTHER
123	PERSONAL CARE SERVICES (Misc. Svcs.)
124	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
125	MENTAL HEALTH SERVICES-CDMH
126	MEDICARE PAYMENTS - PART D PHASED-DOWN
127	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)
128	DENTAL SERVICES
129	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
130	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
131	MENTAL HEALTH DRUG MEDI-CAL-CDADP
134	MEDI-CAL TCM PROGRAM (Misc. Svcs.)
135	EPSDT SCREENS
136	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
140	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
141	LAWSUITS/CLAIMS
143	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)
151	AUDIT SETTLEMENTS
159	BASE RECOVERIES

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	7/2000
ANALYST:	Karen del Gallego
FISCAL REFERENCE NUMBER:	56

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$4,014,207,000	$4,313,642,000
- STATE FUNDS	$2,005,290,300	$2,162,100,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,014,207,000	$4,313,642,000
STATE FUNDS	$2,005,290,300	$2,162,100,800
FEDERAL FUNDS	$2,008,916,700	$2,151,541,200

DESCRIPTION

This policy change (PC) reflects the impact of the Two-Plan Model. Each designated county has two managed care plans, a local initiative and a commercial plan, which provide medically necessary services to Medi-Cal beneficiaries residing within the county. Fresno County has two commercial plans. A regional Two-Plan Model, including Fresno, Kings and Madera Counties is set for implementation in October 2010.

The FY 2009-10 and FY 2010-11 costs include the annual rate redetermination, maternity supplemental adjustment, provider payment reduction (reflects all injunctions through March 2009), risk adjustment for Family/Adult and Aged/Disabled Medi-Cal only rate groups, the QIF sunset impact, and AB 1422 (Chapter 157, Statutes of 2009). Additionally, for FY 2009-10 and FY 2010-11, this policy change reflects the increase in capitation payments related to AB 1422 (Chapter 157, Statutes of 2009), including the additional 11.59% FFP due to the American Recovery and Reinvestment Act of 2009. The tax revenue to the GF is not included in the Medi-Cal budget.

Title XXI payment for the June 2009 capitation was paid in FY 2009-10.

The Department increased payments to managed care plans by drawing down federal matching funds to reimburse plans for a Quality Improvement Assessment Fee (QIF). The QIF provision ended on September 30, 2009.

The cost increase between FY 2009-10 and FY 2010-11 due to increased eligibles is estimated to be $199,086,000. The cost increase between FY 2009-10 and FY 2010-11 due to rate changes is estimated to be $119,356,000. The cost increase for the new eligibles at the increased rate is estimated to be $3,965,000. The total increase between FY 2009-10 and FY 2010-11, excluding line item adjustments, is estimated to be $322,407,000 ($4,342,395,000 - $4,019,988,000 = $322,407,000). The FY 2010-11 capitation rate increase percentage on a fiscal year basis, excluding the impact of the QIF sunset, is 4.41%.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 54

FY 2009-10	Total	Eligible Months	Average Monthly Eligibles
Alameda	$235,748,000	1,433,165	119,430
Contra Costa	$127,931,000	798,195	66,516
Kern	$198,015,000	1,581,708	131,809
Los Angeles	$1,706,395,000	14,745,955	1,228,830
Riverside	$316,367,000	2,539,229	211,602
San Bernardino	$375,342,000	2,957,158	246,430
San Francisco	$91,079,000	577,926	48,161
San Joaquin	$162,864,000	1,197,879	99,823
Santa Clara	$227,304,000	1,541,907	128,492
Stanislaus	$122,414,000	813,956	67,830
Tulare	$153,142,000	1,223,106	101,926
Fresno	$303,386,000	2,383,959	198,663
Subtotal	$4,019,988,000		
June 2009 XXI Payment (65/35)	$5,005,000		
Elimination of LTC increase	($751,000)		
AB 1183 Provider Payment Reduction	($10,460,000)		
Cal Pharmacy Injunction (08-09 & 09-10)	$3,984,000		
Elimination of Optional Benefits	($3,559,000)		
Total FY 2009-10	**$4,014,207,000**	31,794,142	2,649,512

FY 2010-11	Total	Eligible Months	Average Monthly Eligibles
Alameda	$264,355,000	1,515,402	126,284
Contra Costa	$142,284,000	851,399	70,950
Kern	$210,843,000	1,619,070	134,923
Los Angeles	$1,802,249,000	15,245,095	1,270,425
Riverside	$359,416,000	2,732,540	227,712
San Bernardino	$424,949,000	3,176,589	264,716
San Francisco	$97,314,000	607,391	50,616
San Joaquin	$175,464,000	1,268,199	105,683
Santa Clara	$246,339,000	1,630,705	135,892
Stanislaus	$124,103,000	839,111	69,926
Tulare	$157,308,000	1,263,668	105,306
Fresno	$337,771,000	2,602,552	216,879
Subtotal	$4,342,395,000		
CHA vs. Maxwell-Jolly Injunction	$101,000		
Pharmacy Pricing Adjustment	($29,311,000)		
Reinstatement of Optometry	$457,000		
Total FY 2010-11	**$4,313,642,000**	33,351,723	2,779,310

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	12/1987
ANALYST:	Karen del Gallego
FISCAL REFERENCE NUMBER:	57

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$2,523,491,000	$2,870,268,000
- STATE FUNDS	$1,256,423,900	$1,433,141,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,523,491,000	$2,870,268,000
STATE FUNDS	$1,256,423,900	$1,433,141,800
FEDERAL FUNDS	$1,267,067,100	$1,437,126,200

DESCRIPTION

This policy change reflects the impact of the County Organized Health Systems in eleven counties. Effective February 1, 2010, the Health Plan of San Mateo added long term care services to their contract. Currently, all COHS plans provide long term care services to their enrollees. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA). PHC is negotiating with the Department to remove OBRA beneficiaries from their contract effective January 1, 2011. Effective October 1, 2009 PHC expanded into Sonoma County, and Central California Alliance for Health expanded into Merced.

The FY 2009-10 and FY 2010-11 costs include the annual rate redetermination, provider payment reductions (reflects all injunctions through March 2009), post stabilization services reduction and the QIF sunset impact. The FY 2010-11 costs also include the Family Planning rate increase rollback, H1N1 Vaccine, AB 1183 Provider Payment Reduction impact, Cal Pharmacy injunction impact, and the elimination of optional benefits. Additionally, for FY 2009-10 and FY 2010-11, this policy change reflects the increase in capitation payments related to AB 1422 (Chapter 157, Statutes of 2009), including the additional 11.59% FFP due to the American Recovery and Reinvestment Act of 2009. The tax revenue to the GF is not included in the Medi-Cal budget.

The Department increased payments to managed care plans by drawing down federal matching funds to reimburse plans for a Quality Improvement Assessment Fee (QIF). HPSM was the only COHS subject to the QIF. The QIF ended September 30, 2009.

The cost increase between FY 2009-10 and FY 2010-11 due to increased eligibles is estimated to be $173,453,000. The cost increase between FY 2009-10 and FY 10-11 due to rate changes is estimated to be $161,990,000. The cost increase for the new eligibles at the increased rate is estimated to be $9,500,000. The total increase between FY 2009-10 and FY 2010-11, excluding line item adjustments, is estimated to be $344,943,000 ($2,885,348,000 - $2,540,405,000 = $344,943,000). The FY 2010-11 capitation rate increase percentage on a fiscal year basis, excluding the impact of the QIF sunset, is 3.71%.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 55

FY 2009-10	Eligible Months	Average Monthly Eligibles	Total
San Luis Obispo	328,256	27,355	$87,868,000
CalOPTIMA (Orange)	4,172,129	347,677	$1,043,877,000
Monterey	819,780	68,315	$205,409,000
Napa	156,436	13,036	$55,719,000
San Mateo	685,019	57,085	$223,851,000
Santa Barbara	736,247	61,354	$193,697,000
Santa Cruz	413,007	34,417	$116,763,000
Solano	724,403	60,367	$221,602,000
Yolo	317,820	26,485	$98,021,000
Sonoma	437,418	36,452	$145,904,000
Merced	620,212	51,684	$147,696,000
Subtotal			$2,540,405,000
June 2009 XXI Payment			$1,866,000
Elimination of LTC increase			($24,614,000)
AB 1183 Provider Payment Reduction			($3,475,000)
Cal Pharmacy Injunction (08-09 & 09-10)			$10,150,000
Elimination of Optional Benefits			($843,000)
Total FY 2009-10	9,410,727	784,227	**$2,523,491,000**

FY 2010-11	Eligible Months	Average Monthly Eligibles	Total
San Luis Obispo	344,202	28,684	$97,217,000
CalOPTIMA (Orange)	4,391,881	365,990	$1,125,551,000
Monterey	879,068	73,256	$214,807,000
Napa	165,718	13,810	$57,815,000
San Mateo	710,785	59,232	$313,459,000
Santa Barbara	767,774	63,981	$208,423,000
Santa Cruz	426,462	35,539	$126,677,000
Solano	757,118	63,093	$230,429,000
Yolo	330,806	27,567	$106,352,000
Sonoma	582,583	48,549	$202,125,000
Merced	826,375	68,865	$202,493,000
Subtotal			$2,885,348,000
Family Planning Rate Increase Rollback*			$1,338,000
CHA vs. Maxwell-Jolly Injunction			$713,000
Pharmacy Pricing Adjustment			($17,312,000)
Reinstatement of Optometry			$181,000
Total FY 2010-11	10,182,772	848,564	**$2,870,268,000**

* The COHS rates for FY 2010-11 include the impact of twelve months of the Family Planning Rate Increase Rollback. Because the Rollback is now estimated to begin in October 2010, three months reduction in the Rollback savings are included here.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	4/1994
ANALYST:	Karen del Gallego
FISCAL REFERENCE NUMBER:	58

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$687,588,000	$760,759,000
- STATE FUNDS	$343,452,200	$380,958,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$687,588,000	$760,759,000
STATE FUNDS	$343,452,200	$380,958,850
FEDERAL FUNDS	$344,135,800	$379,800,150

DESCRIPTION

The GMC program requires mandatory enrollment of most AFDC, PA/MN, MIC, and Refugee beneficiaries, and Poverty Aid codes 1, 2, 8, 0A, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7X, 82, 8P, and 8R. Aid Codes that can voluntarily enroll are Family codes 3, 4, 6, 40, 42, 45, 46, 4A, 4F, 4G, 4K, 4M, 5K, 7J. Disabled codes 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, Aged codes 10, 14, 16, 1E, 1H, Adult code 86, and BCCTP codes 0N and 0P.

The FY 2009-10 and FY 2010-11 costs include the annual rate redetermination, maternity supplemental payments, provider payment reductions (reflects all injunctions through March 2009) and risk adjustment for Family/Adult and Aged/Disabled Medi-Cal only rate groups. The FY 2010-11 costs also include the Family Planning rate increase rollback, H1N1 Vaccine, AB 1183 Provider Payment Reduction impact, Cal Pharmacy injunction impact, and the elimination of optional benefits. Additionally, for FY 2009-10 and FY 2010-11, this policy change reflects the increase in capitation payments related to AB 1422 (Chapter 157, Statutes of 2009), including the additional 11.59% FFP due to the American Recovery and Reinvestment Act of 2009. The tax revenue to the GF is not included in the Medi-Cal budget.

The Department increased payments to managed care plans by drawing down federal matching funds to reimburse plans for a Quality Improvement Assessment Fee (QIF). The QIF ended on September 30, 2009.

Capitation rates for Geographic Managed Care contracts are currently negotiated by the California Medical Assistance Commission (CMAC). The Department has proposed legislation to transfer the authority for negotiating capitation rates to the Department. It is estimated that the savings from reassigning contract negotiation authority from the CMAC will be $680,000 in FY 2010-11.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 56

FY 2009-10	Eligible Months	Average Monthly Eligibles	Total
Sacramento GMC	2,263,118	188,593	$346,630,000
San Diego GMC	2,437,302	203,109	$342,991,000
Subtotal			$689,621,000
Elimination of LTC increase			($200,000)
AB 1183 Provider Payment Reduction			($1,590,000)
Cal Pharmacy Injunction (08-09 & 09-10)			$674,000
Elimination of Optional Benefits			($917,000)
Total FY 2009-10	4,700,420	391,702	**$687,588,000**

FY 2010-11	Eligible Months	Average Monthly Eligibles	Total
Sacramento GMC	2,363,299	196,942	$380,543,000
San Diego GMC	2,590,264	215,855	$384,251,000
Subtotal			$764,794,000
CHA vs. Maxwell-Jolly Injunction (09-10 & 10-11)			$25,000
CMAC Contract Savings			($680,000)
Pharmacy Pricing Adjustment			($3,442,000)
Reinstatement of Optometry			$62,000
Total FY 2010-11	4,953,563	412,797	**$760,759,000**

The cost increase between FY 2009-10 and FY 2010-11 due to increased eligibles is estimated to be $31,856,000. The cost increase between FY 2009-10 and FY 10-11 due to rate changes is estimated to be $43,280,000. The cost increase for the new eligibles at the increased rate is estimated to be $37,000. The total increase between FY 2009-10 and FY 2010-11, excluding line item adjustments, is estimated to be $75,173,000 ($764,794,000 - $689,621,000 = $75,173,000). The FY 2010-11 capitation rate increase percentage on a fiscal year basis, excluding the impact of the QIF sunset, is 7.78%.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	7/1992
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	62

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$124,460,000	$146,335,000
- STATE FUNDS	$62,230,000	$73,167,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$124,460,000	$146,335,000
STATE FUNDS	$62,230,000	$73,167,500
FEDERAL FUNDS	$62,230,000	$73,167,500

DESCRIPTION

The Department has five contracts under the Program of All-Inclusive Care for the Elderly (PACE) for risk-based capitated life-time care for the frail elderly. The PACE program provides all medical, home and community-based and long-term care services (including adult day health care and in-home support) to Medi-Cal and Medi-Cal/Medicare crossover beneficiaries who are certified by the Department for skilled nursing facility or intermediate care facility level of care. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at a minimum of 90% of the FFS Upper Payment Limits. Beginning January 1, 2009, PACE rates are set on a calendar year basis, rather than October 1 through September 30, to coincide with the time period of the contracts. The 2009 rate setting methodology uses a blend of FFS data on costs incurred by Medi-Cal participants in the MSSP and by the Medi-Cal nursing home resident population historically used for setting PACE rates. Beginning January 1, 2010, budgeted amounts are based on proposed rates.

St. Paul's Homes and Services for the Elderly, a non-profit corporation, has submitted a PACE application for its subsidiary corporation, Community Elder Care of San Diego (CESD), which has been approved. CESD became operational February 1, 2008.

On Lok Senior Health Services expanded into Santa Clara County and became operational January 1, 2009.

The Center for Elders Independence (CEI) operates in Alameda County. Expansion to an additional site in Alameda County became operational May 1, 2009.

Sutter Senior Care (Sutter) currently operates in Sacramento County.

Alta Med Senior Buena Care (Alta Med) operates in Los Angeles County. An additional site in LA County became operational June 1, 2008. An additional expansion site for Los Angeles became operational in October 2009.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 59

PACE dental rates have changes that will be retroactive to January 2009. The prior rate of $8.45 increased to $8.94 for January through June 2009. The rate change results in a retroactive increase of $.049 per member per month for the period January through June 2009.

	Costs	Eligible Months	Average Monthly Enrollment
FY 2009-10			
Centers for Elder Independence	$24,244,000	5,339	445
Sutter Senior Care	$9,560,000	2,618	218
Alta Med Senior Buena Care	$32,364,000	8,217	685
OnLok Senior Health	$53,627,000	12,097	1,008
St. Paul's Homes (CESD)	$4,658,000	1,208	101
Total Capitation Payments	$124,453,000	29,479	2,457
Retroactive Rate Adjustment For FY 2008-09	$7,000		
Total	**$124,460,000**		
FY 2010-11			
Centers for Elder Independence	$30,220,000	6,630	552
Sutter Senior Care	$10,788,000	2,940	245
Alta Med Senior Buena Care	$39,410,000	9,798	816
OnLok Senior Health	$58,384,000	13,224	1,102
St. Paul's Homes (CESD)	$7,533,000	1,961	163
Total Capitation Payments	**$146,335,000**	34,553	2,879

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	7/2004
ANALYST:	Cavan Donovan
FISCAL REFERENCE NUMBER:	1029

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$48,225,000	$51,847,000
- STATE FUNDS	$24,112,500	$25,923,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$48,225,000	$51,847,000
STATE FUNDS	$24,112,500	$25,923,500
FEDERAL FUNDS	$24,112,500	$25,923,500

DESCRIPTION

This policy change reflects the expenditures for Dental Managed Care. Dental managed care is comprised of dental costs related to Sacramento Geographic Managed Care and dental prepaid health plans in Los Angeles.

Assumptions:

1. The dental managed care rates for FY 2009-10 have been used for this estimate. It is estimated that these rates will be implemented in May 2010.

2. Retroactive payments for adjustments scheduled to be paid in a fiscal year subsequent to the year services were provided are shown in the Dental Retroactive Rate Changes policy change.

3. Dental rates for SCAN and PACE are incorporated into the SCAN and PACE policy changes.

4. No rate adjustments have been included for FY 2010-11. The FY 2009-10 rates have been used.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 60

FY 2009-10		Capitation Rate	Average Monthly Eligibles	Total Funds
GMC	7/1/09 - 12/31/09	$8.06	192,642	$9,313,000
	1/1/10 - 6/30/10	$8.24	198,773	$9,831,000
PHP	7/1/09 - 12/31/09	$8.81	267,048	$14,120,000
	1/1/10 - 6/30/10	$9.01	276,603	$14,961,000
				$48,225,000
FY 2010-11				
GMC		$8.24	207,962	$20,570,000
PHP		$9.02	289,116	$31,277,000
				$51,847,000

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	2/1985
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	61

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$27,966,000	$45,727,000
- STATE FUNDS	$13,983,000	$22,756,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$27,966,000	$45,727,000
STATE FUNDS	$13,983,000	$22,756,500
FEDERAL FUNDS	$13,983,000	$22,970,500

DESCRIPTION

The Senior Care Action Network (SCAN) project in Los Angeles, San Bernardino, and Riverside Counties provides services on a capitated basis for persons with both Medicare and Medi-Cal coverage and those who become certified for SNF and ICF level of care. This project provides medical, social, and case management services. Total enrollment is projected to be 7,913 in June 2010 and 8,029 by June 2011.

To determine 2009 rates for dually eligible enrollees, SCAN provided the Department with a bid based upon its costs for Medi-Cal services rendered to this population. To determine 2009 rates for nursing home eligible participants, the Department used cost data for MSSP as a point of comparison and made adjustments to SCAN's bid. FY 2009-10 funding includes projected costs for the January 1, 2010 annual rate determination.

Dental costs are included in the SCAN capitation rates for July 2009 through December 2009 are budgeted in this policy change. Effective January 2010, SCAN no longer included dental costs in their rates as those costs are now covered by Medicare.

AB 1422 (Chapter 175, Statutes of 2009) imposes a managed care organization (MCO) tax on the total operating revenue of Medi-Cal managed care plans. This policy change reflects the increase in capitation payments related to AB 1422, including the additional 11.59% FFP due to the American Recovery and Reinvestment Act of 2009 for FY 2010-11. The increase for the retroactive period of January 1, 2009 through June 30, 2009 and FY 2009-10 is budgeted in the Increase in Capitation Rates for MCO Tax policy change. The tax revenue to the GF is not included in the Medi-Cal budget.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 63

	Costs	Eligible Months	Average Monthly Enrollment
FY 2009-10			
Los Angeles	$26,445,000	58,798	4,900
Riverside	$8,455,000	18,590	1,549
San Bernardino	$4,353,000	9,712	809
Total Capitation Payments	$39,253,000	87,100	7,258
Retroactive Rate Adjustments for FY 2008-09	($11,287,000)		
Total	**$27,966,000**		
FY 2010-11			
Los Angeles	$30,819,000	64,686	5,391
Riverside	$9,831,000	20,426	1,702
San Bernardino	$5,077,000	10,554	880
Total Capitation Payments	**$45,727,000**	95,666	7,973

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	5/1985
ANALYST:	Karen del Gallego
FISCAL REFERENCE NUMBER:	63

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$8,905,000	$11,300,000
- STATE FUNDS	$4,452,500	$5,625,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,905,000	$11,300,000
STATE FUNDS	$4,452,500	$5,625,500
FEDERAL FUNDS	$4,452,500	$5,674,500

DESCRIPTION

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional PCCM program.

Primary care case management (PCCM) plan contractors participate in a program savings sharing agreement with the Department. Shared savings are expected to be produced by the PCCMs' effective case management of services for which the PCCM is not at risk. Due to the long period of time needed to make the final determinations, savings sharing has not been determined for calendar year 2009 and beyond.

This policy change includes the impact of the rate change effective April 1, 2009 through December 31, 2009. The current contract has been extended through December 31, 2010 with new rates effective January 1, 2010. The new rates include all drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) prior to January 1, 2007. The impact of Assembly Bill 1422 (Chapter 157, Statutes of 2009) has been incorporated into the FY 2010-11 rates.

The Department increased payments to managed care plans by drawing down federal matching funds to reimburse plans for a 6% Quality Improvement Assessment Fee (QIF). Managed care plan rates were adjusted to include the QIF in their rates on their anniversary dates beginning July 1, 2005. Effective January 1, 2008, the QIF payment from the plans dropped from 6% to 5.5%. The QIF ended September 30, 2009.

AB 1422 (Chapter 175, Statutes of 2009) imposes a managed care organization (MCO) tax on the total operating revenue of MediCal managed care plans. This policy change reflects the increase in capitation payments related to AB 1422, including the additional 11.59% FFP due to the American Recovery and Reinvestment Act of 2009 for FY 2010-11. The increase for the retroactive period of January 1, 2009 through June 30, 2009 and FY 2009-10 is budgeted in the Increase in Capitation Rates for MCO Tax policy change. The tax revenue to the GF is not included in the Medi-Cal budget.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 66

	TF	Eligible Months	Average Monthly Enrollment
FY 2009-10	**$8,905,000**	8,631	719
FY 2010-11	**$11,300,000**	9,888	824

FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)

BASE POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	3/1993
ANALYST:	Karen del Gallego
FISCAL REFERENCE NUMBER:	66

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$2,869,000	$3,217,000
- STATE FUNDS	$1,434,500	$1,608,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,869,000	$3,217,000
STATE FUNDS	$1,434,500	$1,608,500
FEDERAL FUNDS	$1,434,500	$1,608,500

DESCRIPTION

The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out of home placement. The Department's contract with the Family Mosaic Project is effective January 1, 2008 through December 31, 2012. Family Mosaic has a projected enrollment of 145 by June 2010 and 145 during FY 2010-11.

	Costs	Eligible Months	Average Monthly Enrollment
FY 2009-10 Total	**$2,869,000**	1,552	129
FY 2010-11 Total	**$3,217,000**	1,740	145

PHP

BASE POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/2002
ANALYST:	Karen del Gallego
FISCAL REFERENCE NUMBER:	140

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$2,604,000	$1,932,000
- STATE FUNDS	$1,303,900	$966,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,604,000	$1,932,000
STATE FUNDS	$1,303,900	$966,900
FEDERAL FUNDS	$1,300,100	$965,100

DESCRIPTION

This Base Policy Change includes the PHP Base Estimate. Kaiser (KP Cal) is the only remaining PHP and has a contract in Marin County. KP Cal PHP no longer operates as the Medi-Cal managed care contractor in Sonoma County as of September 30, 2009.

Sonoma was one of the expansion counties under the Managed Care expansion plan. It joined Partnership Health Plan of California (PHC), a County Organized Health System's health plan in October 2009.

The capitation rates include the rate redetermination, the impact of the QIF sunset, and AB 1422 (Chapter 157, Statutes of 2009).

The Department increased payments to managed care plans by drawing down federal matching funds to reimburse plans for a 6% Quality Improvement Assessment Fee (QIF). Managed care plan rates were adjusted to include the QIF in their rates on their anniversary dates beginning July 1, 2005. Effective January 1, 2008, the QIF dropped from 6% to 5.5%. The QIF reduction is included in the rates. The QIF ended September 30, 2009.

The Department develops the rates for the PHP plans.

FY 2009-10	Total	Eligible Months	Average Monthly Eligibles
081 - Kaiser Foundation Health Plan	$1,813,000	9,817	818
087 - Kaiser Foundation Health Plan	$791,000	4,686	391
Total FY 2009-10	**$2,604,000**	14,503	1,209

FY 2010-11	Total	Eligible Months	Average Monthly Eligibles
081 - Kaiser Foundation Health Plan	**$1,932,000**	10,418	868

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	4/1993
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	22

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$3,205,311,000	$3,392,863,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,205,311,000	$3,392,863,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,205,311,000	$3,392,863,000

DESCRIPTION

The Department of Health Care Services provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal beneficiaries, via Interagency Agreements (IA) 03-75676 and 04-35840, for the In-Home Supportive Services (IHSS) Personal Care Services Program (PCSP) and Independence Plus Waiver (IPW) administered by CDSS.

The estimates below were provided by CDSS. FFP for the county cost of administering the PCSP is in the Other Administration section of the Estimate.

CASH BASIS
(In Thousands)

FY 2009-10

TF	CDSS GF	County Share	FFP Regular	FFP ARRA	Total FFP
$5,213,067	$1,305,221	$702,536	$2,602,133	$603,178	**$3,205,311**

FY 2010-11

TF	CDSS GF	County Share	FFP Regular	FFP ARRA	Total FFP
$5,548,050	$1,401,050	$754,137	$2,754,381	$638,482	**$3,392,863**

This policy change reflects FMAP changes due to the American Recovery and Reinvestment Act of 2009 (ARRA), including the assumed extension through June 30, 2011.

MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS

BASE POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	7/1988
ANALYST:	Humei Wang
FISCAL REFERENCE NUMBER:	76

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$2,284,989,000	$2,583,989,000
- STATE FUNDS	$1,210,202,000	$1,371,466,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,284,989,000	$2,583,989,000
STATE FUNDS	$1,210,202,000	$1,371,466,000
FEDERAL FUNDS	$1,074,787,000	$1,212,523,000

DESCRIPTION

The Buy-In Base Estimate reflects expenditures for Part A and Part B premiums for Medi-Cal eligibles that are also eligible for Medicare coverage.

This policy change also includes adjustments due to reconciliations of state and federal data.

FY 2009-10	Part A	Part B
Eligibles	161,693	1,075,638
Rate 07/2009-12/2009	$443.00	$96.40
Rate 01/2010-06/2010	$461.00	$110.50
FY 2010-11		
Eligibles	166,107	1,101,196
Rate 07/2010-12/2010	$461.00	$110.50
Rate 01/2011-06/2011 (est.)	$480.00	$126.70

MENTAL HEALTH SERVICES-CDMH

BASE POLICY CHANGE NUMBER:	125
IMPLEMENTATION DATE:	7/1997
ANALYST:	Irene Gen
FISCAL REFERENCE NUMBER:	75

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$1,247,729,000	$1,606,979,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,247,729,000	$1,606,979,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,247,729,000	$1,606,979,000

DESCRIPTION

This policy change includes the estimated cost of specialty mental health services administered by the California Department of Mental Health (CDMH). This policy change budgets only the FFP.

CMS granted a one year waiver renewal through September 30, 2010 for the current Specialty Mental Health Waiver. The Department continues to work with CMS for approval of the second year waiver renewal term.

This policy change reflects FMAP changes due to the American Recovery and Reinvestment Act of 2009 (ARRA), including the assumed extension through June 30, 2011.

EPSDT Contract # 02-25271.
Outpatient Contract # 02-25271.
San Mateo Pharm/Lab Contract # 01-16094/02-25271.

MENTAL HEALTH SERVICES-CDMH

BASE POLICY CHANGE NUMBER: 125

CASH BASIS
(Dollars in Thousands)

FY 2009-10	**Title XIX FFP (50/50)**	**FFP ARRA**	**Total**
EPSDT	$542,857	$109,826	$652,683
Outpatient	$362,097	$78,420	$440,517
Inpatient-EDS	$123,056	$26,071	$149,127
San Mateo Pharm/Lab	$4,486	$916	$5,402
TOTAL	$1,032,496	$215,233	**$1,247,729**

FY 2010-11	**Title XIX**	**FFP ARRA**	**Total**
EPSDT	$738,345	$104,623	$842,968
Outpatient	$500,090	$75,444	$575,534
Inpatient-EDS	$163,723	$24,312	$188,035
San Mateo Pharm/Lab	$359	$83	$442
TOTAL	$1,402,517	$204,462	**$1,606,979**

	Total Funds	**CDMH GF**	**County / Other**	**FFP Regular**	**FFP ARRA**	**TOTAL FFP**
FY 2009-10	$2,169,323	$461,664	$459,930	$1,032,496	$215,233	**$1,247,729**
FY 2010-11	$2,632,897	$607,390	$418,528	$1,402,517	$204,462	**$ 1,606,979**

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER:	126
IMPLEMENTATION DATE:	1/2006
ANALYST:	Karen Fairgrieves
FISCAL REFERENCE NUMBER:	1019

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$1,312,104,000	$1,376,469,000
- STATE FUNDS	$1,312,104,000	$1,376,469,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,312,104,000	$1,376,469,000
STATE FUNDS	$1,312,104,000	$1,376,469,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

On January 1, 2006, Medicare's Part D benefit began. Part D provides a prescription drug benefit to all dual eligibles and other Medicare eligibles that enroll in Part D. Dual eligibles had previously received drug benefits through Medi-Cal.

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligibles. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreases by 1 ⅔% each year until it reaches 75% (CY 2007 = 88 ⅓%, CY 2008 = 86 ⅔%, etc). The Medicare Modernization Act of 2003 (MMA) sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly clawback cost per dual eligible or the per member per month (PMPM) rate.

On February 18, 2010, CMS announced that the increased FMAP provided under ARRA would be applied to states' Medicare Part D payments. This temporary adjustment of additional 11.59% in Medi-Cal's FMAP is retroactive to October 1, 2008. The savings generated is shown under Medicare Payments – Part D Phased-down ARRA policy change.

Medi-Cal's Part D PMPM rate:

Calendar Year	PMPM rate
2006	$ 89.02
2007	$ 93.37
2008	$ 93.15
2009	$ 99.82
2010	$102.54
2011	$105.28 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 126

Medi-Cal's total payments on a cash basis and average monthly eligibles by fiscal year:

Fiscal Year	Total Payment	Ave. Monthly Eligibles
FY 2005-06*	$ 207,397,571	936,590
FY 2006-07	$1,222,488,362	1,010,020
FY 2007-08	$1,147,521,645	1,024,987
FY 2008-09	$1,213,987,168	1,060,669

*January and February 2006 payments were paid in eight installments with two installment payments in FY 2005-06 and the remaining six in FY 2006-07. In March of 2006, CMS added retroactive Part D eligibility and auto-enrollment for dual eligibles.

Assumptions:

1. The growth increase in California's PMPM for calendar year 2009 was 9.26%, for a $99.82 PMPM. The 9.26% increase is an adjusted national growth percentage for the Phased-down calculation and was determined by CMS using National Health Expenditures and CMS' actual Part D prescription drug event data of 7.54%; in addition, an adjustment to account for revisions to prior year estimates of per capita drug cost growth from 2003 to 2006 of 1.60% was applied.

2. The growth increase in California's PMPM for calendar year 2010 is 4.77%, for a $102.54 PMPM. The 2010 increase is based on the annual percentage increase (API) in per capita Part D expenditures of 5.79%, along with an adjustment to account for revisions to prior year estimates of per capita drug cost growth from 2003 to 2006 of 0.11% and from 2007 to 2009 of -1.07% .

3. The estimated growth increase in California's PMPM for calendar year 2011 is 4.77%, for an estimated $105.28 PMPM. The 2011 estimated PMPM is based an API in per capita Part D expenditures of 4.63%, along with an adjustment to account for revisions to the per capita drug cost growth from 2003 to 2006 of an estimated .14%. No adjustment has been assumed in prior year estimates for 2007 to 2010.

4. Phase-down payments have a two-month lag. For example, the invoice for the Medi-Cal beneficiaries eligible for Medicare Part D in May 2009 is received in June 2009 and payment is due in July 2009.

5. The average monthly eligibles are estimated using a growth trend in the monthly dual eligibles for July 2008–February 2010.

6. The Phased-down Contribution is funded 100% by State General Fund.

	Payment Months	Est. Ave. Monthly Eligibles	Est. Ave. Monthly Cost	Total Cost
FY 2009-10	12	1,085,599	$109,342,000	**$1,312,104,000**
FY 2010-11	12	1,108,786	$114,705,750	**$1,376,469,000**

HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)

BASE POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	7/1990
ANALYST:	Calah Frazier
FISCAL REFERENCE NUMBER:	23

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$1,243,687,000	$1,064,485,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,243,687,000	$1,064,485,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,243,687,000	$1,064,485,000

DESCRIPTION

The California Department of Developmental Services (CDDS), under a federal Home and Community Based Services (HCBS) waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The HCBS waiver allows the State to offer these services as "medical assistance" to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). The CDDS budget is on an accrual basis while the DHCS budget is on a cash basis. The following estimates have been provided by CDDS. This estimate includes the CDDS' budget reductions for FY 2010-11.

This policy change reflects FMAP changes due to the American Recovery and Reinvestment Act of 2009 (ARRA).

CASH BASIS

(In Thousands)	Total Funds	CDDS GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2009-10	$2,018,533	$774,846	$1,009,266	$234,421	**$1,243,687**	01-15834
FY 2010-11	$1,907,902	$843,417	$953,951	$110,534	**$1,064,485**	01-15834

DENTAL SERVICES

BASE POLICY CHANGE NUMBER:	128
IMPLEMENTATION DATE:	7/1988
ANALYST:	Cavan Donovan
FISCAL REFERENCE NUMBER:	135

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$553,103,000	$562,636,000
- STATE FUNDS	$276,551,500	$281,318,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$553,103,000	$562,636,000
STATE FUNDS	$276,551,500	$281,318,000
FEDERAL FUNDS	$276,551,500	$281,318,000

DESCRIPTION

This policy change reflects expenditures for the Delta Dental base estimate. Delta Dental has an at risk contract to provide dental services to Medi-Cal beneficiaries at a prepaid capitated rate per eligible. These dental costs are for FFS Medi-Cal beneficiaries and include the impact of the reduction to dental services for adults which was effective July 1, 2009. Dental costs for beneficiaries with dental managed care plans are shown in a separate base policy change.

Assumptions:

1. The capitation rates of $8.97 for regular eligibles and $39.76 for refugees were effective August 1, 2008 through July 31, 2009. The new rates for July 1 – July 31, 2009 are $8.48 for regular eligibles and $9.36 for refugees. The new rates for August 1, 2009 – July 31, 2010 are $6.76 for regular eligibles and $9.50 for refugees. It is estimated that these rates will be implemented in May 2010.

2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ended June 30, 2008 resulted in an underwriting loss of $3.3 million. According to contract distribution provisions the state will contribute $1.6 million and Delta will contribute $1.6 million.

3. Full federal funding is available for refugees. The funding adjustment shifting normal state share to 100% federal funds for refugees is aggregated and shown in the Refugee Policy Change.

4. No rate adjustment has been included for FY 2010-11. The rates effective August 1, 2009 have been used for FY 2010-11 at this time.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 128

FY 2009-10	Rate[1]	Average Monthly Eligibles	Total Funds
Regular 7/09	$8.48	5,919,229	$50,195,000
Regular 8/09 – 6/10	$6.76	6,290,659	$467,773,000
Refugee 7/09	$9.36	3,350	31,000
Refugee[3] 8/09-6/10	$9.50	3,733	390,000
Other FFS	Non-Capitated	511,249	$33,069,000
		Sub-total	$551,458,00
Underwriting Loss [2]			$1,645,000
		FY 2009-10 Dental	**$553,103,000**
FY 2010-11			
Regular 7/10-6/11	$6.76	6,487,933	$526,301,000
Refugee[3] 7/10-6/11	$9.50	3,628	$414,000
Other FFS	Non-Capitated	543,442	$35,921,000
		FY 2010-11 Dental	**$562,636,000**

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	7/1997
ANALYST:	Calah Frazier
FISCAL REFERENCE NUMBER:	77

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$319,561,000	$273,220,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$319,561,000	$273,220,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$319,561,000	$273,220,000

DESCRIPTION

This Policy Change includes the estimated cost of the California Department of Developmental Services' (CDDS) Developmental Centers (DCs) and State Operated Small Facilities (SOSFs). There are 5 DCs and 2 SOSFs statewide.

The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOSFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

The CDDS budget is on an accrual basis, while the DHCS budget is on a cash basis. The following estimates have been provided by CDDS. This estimate includes CDDS' budget reductions.

This policy change reflects FMAP changes through December 31, 2010 due to the American Recovery and Reinvestment Act of 2009 (ARRA).

CASH BASIS

(In Thousands)	Total Funds	CDDS GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2009-10	$528,920	$209,359	$263,227	$56,334	**$319,561**	03-75282/83
FY 2010-11	$477,238	$204,018	$238,485	$34,735	**$273,220**	03-75282/83

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	130
IMPLEMENTATION DATE:	7/1991
ANALYST:	Calah Frazier
FISCAL REFERENCE NUMBER:	26

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$207,131,000	$152,331,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$207,131,000	$152,331,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$207,131,000	$152,331,000

DESCRIPTION

Federal financial participation (FFP) is paid to the California Department of Developmental Services (CDDS) for targeted case management services for Medi-Cal eligible clients served by the 21 CDDS Regional Centers.

The CDDS budget is on an accrual basis, while the DHCS budget is on a cash basis. The following estimates have been provided by CDDS. This estimate includes the CDDS' budget reductions.

This policy change reflects FMAP changes due to the American Recovery and Reinvestment Act of 2009 (ARRA).

CASH BASIS

(Dollars in Thousands)	Total Funds	CDDS GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2009-10	$336,623	$129,492	$168,312	$38,819	**$207,131**	03-75284
FY 2010-11	$273,097	$120,766	$136,549	$15,782	**$152,331**	03-75284

MENTAL HEALTH DRUG MEDI-CAL-CDADP

BASE POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	7/1997
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	84

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$119,484,000	$60,157,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$119,484,000	$60,157,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$119,484,000	$60,157,000

DESCRIPTION

This policy change includes the estimated cost of the federal Title XIX share of the Mental Health Drug Medi-Cal Program.

The budget estimates below were provided by the California Department of Alcohol and Drug Programs.

This policy change reflects FMAP changes due to the American Recovery and Reinvestment Act of 2009 (ARRA), including the assumed extension through June 30, 2011.

CASH BASIS

Dollars in thousands

	Total Funds	DADP GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2009-10	$204,206	$84,722	$95,579	$23,905	**$119,484**	04-35640
FY 2010-11	$108,215	$48,058	$47,908	$12,249	**$60,157**	04-35640

MEDI-CAL TCM PROGRAM (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	6/1995
ANALYST:	Irene Gen
FISCAL REFERENCE NUMBER:	27

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$60,581,000	$70,275,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$60,581,000	$70,275,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$60,581,000	$70,275,000

DESCRIPTION

The Targeted Case Management (TCM) program assists Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, linkage and consultation, assistance with accessing services, crisis assistance planning, and periodic review. Through rates established in the annual cost reports, local governmental agencies submit invoices to the Department to claim FFP for these case services. The following target groups are currently served in the TCM program: public health, public guardian, linkages, outpatient, adult probation, and community.

On March 3, 2008, CMS published an Interim Final Rule (CMS 2237-IFC) to clarify the situations in which Medicaid will pay for case management activities and when it is not available. On June 30, 2009, CMS partially rescinded this regulation. The Department is currently analyzing the remaining sections of the regulations to assess the impact on this program.

SB 308 (Chapter 253, Statutes of 2003) redefined local governmental agencies to include Native American tribes, which allows them to participate in TCM and MAA programs.

Cash Basis	FY 2009-10	FY 2010-11
2007-08 Invoices	$286,000	$0
2008-09 Invoices	$19,450,000	$22,562,000
2009-10 Invoices	$40,845,000	$47,381,000
2010-11 Invoices	$0	$332,000
Total	**$60,581,000**	**$70,275,000**

EPSDT SCREENS

BASE POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	7/2001
ANALYST:	Jade Li
FISCAL REFERENCE NUMBER:	136

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$58,891,000	$60,555,000
- STATE FUNDS	$29,445,500	$30,277,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$58,891,000	$60,555,000
STATE FUNDS	$29,445,500	$30,277,500
FEDERAL FUNDS	$29,445,500	$30,277,500

DESCRIPTION

The CHDP program is responsible for the screening component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit of the Medi-Cal program. The health assessments, immunizations, and laboratory screening procedures for Medi-Cal children are funded 50 percent GF and 50 percent FFP. This policy change reflects screening costs for the EPSDT program.

Costs are the estimated number of screens times the estimated average cost per screen for FY 2009-10 and FY 2010-11, based on a historical trend dating back to July 2001.

FY 2009-10
Screens 990,912 x $59.43 (weighted average) = **$58,891,000*** (rounded)

FY 2010-11
Screens 1,004,228 x $60.3 (weighted average) = **$60,555,000*** (rounded)

*Includes $33,000 in each FY for CLPP Funding for EPSDT Lead Screens. Costs are based on information provided by the Children's Medical Services Branch on costs for childhood lead screens. It is assumed that $33,000 in CLPP funding, Item 4260-101-0080, will be used for the non-federal share in both FYs.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	4/2000
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	32

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$31,767,000	$38,020,000
- STATE FUNDS	$15,883,500	$19,010,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,767,000	$38,020,000
STATE FUNDS	$15,883,500	$19,010,000
FEDERAL FUNDS	$15,883,500	$19,010,000

DESCRIPTION

AB 668 (Chapter 896, Statutes of 1998) required Medi-Cal to add personal care services (PCS) to the Nursing Facility (NF) Waivers. This policy change reflects Waiver PCS provided through county In-Home Supportive Services programs to waiver beneficiaries, paid by interagency agreement 03-75898 with the California Department of Social Services (CDSS).

Assumptions:

1. The number of current NF A/B LOC Waiver beneficiaries using Waiver PCS is estimated to increase by an average of 11 per month in FY 2009-10 and 21 per month in FY 2010-11.

2. The number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by two per month in FY 2009-10 and three per month in FY 2010-11.

3. The Department expects to enroll 148 beneficiaries during FY 2009-10 and 270 beneficiaries during FY 2010-11 into the CCT Demonstration Project. 75% of the beneficiaries are expected to use waiver personal care services.

4. The average cost/hour is $10.64 for FY 2009-10 and FY 2010-11.

CASH BASIS

FY 2009-10 Costs: $31,767,000
FY 2010-11 Costs: $38,020,000

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	140
IMPLEMENTATION DATE:	1/1993
ANALYST:	Irene Gen
FISCAL REFERENCE NUMBER:	91

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$5,288,000	$4,586,000
- STATE FUNDS	$2,644,000	$2,293,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,288,000	$4,586,000
STATE FUNDS	$2,644,000	$2,293,000
FEDERAL FUNDS	$2,644,000	$2,293,000

DESCRIPTION

This policy change estimates the cost of the premium payouts for the Department's Health Insurance Premium Payment (HIPP) program. Since premiums are paid outside of the regular Medi-Cal claims payment procedure, premium costs must be separately budgeted.

On January 1, 2008, the State Plan was amended to remove HIV/AIDS as an automatic HIPP-eligible condition. Effective March 1, 2010, premiums will no longer be paid for beneficiaries who have a diagnosis of HIV/AIDS for whom it is not cost effective.

Assumptions:

1. The average monthly premium cost is estimated to be $520.29 in FY 2009-10 and $549.13 in FY 2010-11.

2. The average monthly HIPP enrollment is estimated to be 847 in FY 2009-10 and 696 in FY 2010-11.

3. Total costs will be $5,288,000 TF ($2,644,000 GF) in FY 2009-10 and $4,586,000 TF ($2,293,000 GF) in FY 2010-11.

   $520.29 x 847 x 12 Months = **$5,288,000 TF ($2,644,000 GF) FY 2009-10**

   $549.13 x 696 x 12 Months = **$4,586,000 TF ($2,293,000 GF) FY 2010-11**

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	141
IMPLEMENTATION DATE:	7/1989
ANALYST:	Irene Gen
FISCAL REFERENCE NUMBER:	93

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$2,516,000	$1,865,000
- STATE FUNDS	$1,258,000	$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,516,000	$1,865,000
STATE FUNDS	$1,258,000	$932,500
FEDERAL FUNDS	$1,258,000	$932,500

DESCRIPTION

This policy change reflects the cost of Medi-Cal lawsuit judgments, settlements, and attorney fees that are not shown in other policy changes.

	Committed 2009-10	Balance 2009-10	Budgeted 2009-10	Budgeted 2010-11
Attorney Fees <$5,000	$470	$49,530	$50,000 *	$50,000 *
Provider Settlements <$75,000	$505,948	$1,094,052	$1,600,000 *	$1,600,000 *
Beneficiary Settlements <$ 2,000	$0	$15,000	$15,000 *	$15,000 *
Small Claims Court	$4,676	$195,324	$200,000 *	$200,000 *
Other Attorney Fees	$519,581	$0	$520,000	$0
Other Provider Settlements	$131,276	$0	$131,000	$0
Other Beneficiary Settlements	$0	$0	$0	$0
TOTALS			**$2,516,000 ***	**$1,865,000 ***

* Represents potential totals.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	7/1997
ANALYST:	Devon Dyer
FISCAL REFERENCE NUMBER:	1083

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$1,020,000	$1,028,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,020,000	$1,028,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,020,000	$1,028,000

DESCRIPTION

The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments which provide the case management services. Some of these services are provided to Medi-Cal eligibles. To the extent that local governments provide case management services to Medi-Cal eligibles, federal matching funds can be claimed.

This policy change reflects the Title XIX federal matching funds for Benefits costs involving case management activities under the State Plan.

The estimates below were provided by CDPH.

CASH BASIS

FY 2009-10	DHCS FFP	CDPH CLPP Fee Funds	IA #
Local Assistance	**$1,020,000**	$1,020,000	07-65689

FY 2010-11	DHCS FFP	CDPH CLPP Fee Funds	IA #
Local Assistance	**$1,028,000**	$1,028,000	07-65689

AUDIT SETTLEMENTS

BASE POLICY CHANGE NUMBER:	151
IMPLEMENTATION DATE:	7/2008
ANALYST:	Irene Gen
FISCAL REFERENCE NUMBER:	110

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

This policy change includes funds for audit settlements with the federal government.

Repayment of Federal audit A-09-06-00032 is budgeted in the Fiscal Intermediary section of the Estimate.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	7/1987
ANALYST:	Cavan Donovan
FISCAL REFERENCE NUMBER:	127

	FY 2009-10	FY 2010-11
FULL YEAR COST - TOTAL FUNDS	-$218,944,000	-$218,716,000
- STATE FUNDS	-$126,856,500	-$126,724,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$218,944,000	-$218,716,000
STATE FUNDS	-$126,856,500	-$126,724,000
FEDERAL FUNDS	-$92,087,500	-$91,992,000

DESCRIPTION

Budget Act Language allows all recoveries to be credited to the Health Care Deposit Fund and to be used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, lawsuit settlements, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances.

Assumptions:

1. The General Fund ratio for collections is estimated to be 57.94% in both FY 2009-10 and FY 2010-11.

2. Effective October 2009, Health Insurance recoveries are being collected through offsets in Medi-Cal payments rather than the receipt of a check. This change has been incorporated into the base.

3. Providers have been requesting offsets in Medi-Cal payments instead of sending in a payment. This change is reflected in lower General Collections shown below. The increase in offsets have been incorporated into the base.

Estimated Base Recoveries:	**FY 2009-10**	**FY 2010-11**
Personal Injury Collections	$39,000,000	$39,000,000
Workers' Comp. Contract	$2,600,000	$2,500,000
Health Insurance	$594,000	$0
H.I. Contingency Contract	$67,000,000	$57,400,000
General Collections	$109,751,000	$119,816,000
TOTAL	**$218,945,000**	**$218,716,000**