

**MEDI-CAL  
MAY 2012  
LOCAL ASSISTANCE ESTIMATE  
for  
FISCAL YEARS  
2011-12 and 2012-13**

# 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



**EDMUND G. BROWN JR.**  
Governor  
State of California

Diana Dooley  
Secretary  
California Health and Human Services Agency

Toby Douglas  
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 2011-12

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>				
52	TWO PLAN MODEL	\$5,827,565,000	\$2,925,830,200	\$2,901,734,800
53	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,507,033,000	\$1,758,867,700	\$1,748,165,300
54	GEOGRAPHIC MANAGED CARE	\$989,876,000	\$497,189,600	\$492,686,400
57	PACE (Other M/C)	\$145,741,000	\$72,870,500	\$72,870,500
58	DENTAL MANAGED CARE (Other M/C)	\$55,803,000	\$27,901,500	\$27,901,500
59	SENIOR CARE ACTION NETWORK (Other M/C)	\$35,284,000	\$17,642,000	\$17,642,000
62	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,354,000	\$6,177,000	\$6,177,000
63	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,887,000	\$1,443,500	\$1,443,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$10,576,543,000</b>	<b>\$5,307,922,000</b>	<b>\$5,268,621,000</b>
<b>OTHER</b>				
128	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,697,785,000	\$2,697,785,000	\$0
129	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,477,512,000	\$1,155,749,000	\$1,321,763,000
130	MENTAL HEALTH SERVICES-CDMH	\$1,228,325,000	\$1,228,325,000	\$0
131	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,400,152,000	\$0	\$1,400,152,000
132	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,115,755,000	\$1,115,755,000	\$0
134	DENTAL SERVICES	\$482,799,000	\$245,027,100	\$237,771,900
135	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$262,857,000	\$262,857,000	\$0
137	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$148,553,000	\$148,553,000	\$0
138	DRUG MEDI-CAL-CDADP	\$58,670,000	\$58,670,000	\$0
139	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$59,617,000	\$59,617,000	\$0
140	EPSDT SCREENS	\$52,096,000	\$26,048,000	\$26,048,000
141	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$35,510,000	\$17,755,000	\$17,755,000
144	LAWSUITS/CLAIMS	\$11,354,000	\$5,677,000	\$5,677,000
149	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,414,000	\$1,207,000	\$1,207,000
150	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,503,000	\$1,503,000	\$0
164	BASE RECOVERIES	-\$265,809,000	-\$106,722,000	-\$159,087,000
	<b>OTHER SUBTOTAL</b>	<b>\$9,769,093,000</b>	<b>\$6,917,806,100</b>	<b>\$2,851,286,900</b>
	<b>GRAND TOTAL</b>	<b>\$20,345,636,000</b>	<b>\$12,225,728,100</b>	<b>\$8,119,907,900</b>

## SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2012-13

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>				
52	TWO PLAN MODEL	\$6,734,508,000	\$3,381,119,200	\$3,353,388,800
53	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,622,780,000	\$1,817,879,500	\$1,804,900,500
54	GEOGRAPHIC MANAGED CARE	\$1,147,888,000	\$576,438,600	\$571,449,400
57	PACE (Other M/C)	\$175,408,000	\$87,704,000	\$87,704,000
58	DENTAL MANAGED CARE (Other M/C)	\$54,807,000	\$27,403,500	\$27,403,500
59	SENIOR CARE ACTION NETWORK (Other M/C)	\$14,944,000	\$7,472,000	\$7,472,000
62	AIDS HEALTHCARE CENTERS (Other M/C)	\$14,157,000	\$7,078,500	\$7,078,500
63	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,887,000	\$1,443,500	\$1,443,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$11,767,379,000</b>	<b>\$5,906,538,800</b>	<b>\$5,860,840,200</b>
<b>OTHER</b>				
128	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,525,036,000	\$2,525,036,000	\$0
129	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,485,702,000	\$1,161,273,000	\$1,324,429,000
130	MENTAL HEALTH SERVICES-CDMH	\$1,677,313,000	\$1,677,313,000	\$0
131	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,465,483,000	\$0	\$1,465,483,000
132	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,089,699,000	\$1,089,699,000	\$0
134	DENTAL SERVICES	\$526,115,000	\$266,685,100	\$259,429,900
135	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$205,349,000	\$205,349,000	\$0
137	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$138,469,000	\$138,469,000	\$0
138	DRUG MEDI-CAL-CDADP	\$154,869,000	\$154,869,000	\$0
139	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$57,621,000	\$57,621,000	\$0
140	EPSDT SCREENS	\$53,242,000	\$26,621,000	\$26,621,000
141	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$38,751,000	\$19,375,500	\$19,375,500
144	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$932,500
149	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,471,000	\$735,500	\$735,500
150	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$1,028,000	\$0
164	BASE RECOVERIES	-\$266,256,000	-\$106,902,000	-\$159,354,000
	<b>OTHER SUBTOTAL</b>	<b>\$10,155,757,000</b>	<b>\$7,218,104,600</b>	<b>\$2,937,652,400</b>
	<b>GRAND TOTAL</b>	<b>\$21,923,136,000</b>	<b>\$13,124,643,400</b>	<b>\$8,798,492,600</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2012 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2011 ESTIMATE  
FISCAL YEAR 2011-12**

NO.	POLICY CHANGE TITLE	2011-12 APPROPRIATION		NOV. 2011 EST. FOR 2011-12		MAY 2012 EST. FOR 2011-12		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>											
52	TWO PLAN MODEL	\$4,612,823,000	\$2,306,154,500	\$5,144,969,000	\$2,560,930,100	\$5,827,565,000	\$2,901,734,800	\$1,214,742,000	\$595,580,300	\$682,596,000	\$340,804,700
53	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,007,139,000	\$1,498,688,600	\$3,528,077,000	\$1,758,747,500	\$3,507,033,000	\$1,748,165,300	\$499,894,000	\$249,476,700	-\$21,044,000	-\$10,582,200
54	GEOGRAPHIC MANAGED CARE	\$784,013,000	\$391,744,100	\$861,867,000	\$428,942,400	\$989,876,000	\$492,686,400	\$205,863,000	\$100,942,300	\$128,009,000	\$63,744,000
57	PACE (Other M/C)	\$153,098,000	\$76,549,000	\$152,252,000	\$76,126,000	\$145,741,000	\$72,870,500	-\$7,357,000	-\$3,678,500	-\$6,511,000	-\$3,255,500
58	DENTAL MANAGED CARE (Other M/C)	\$61,319,000	\$30,659,500	\$58,650,000	\$29,325,000	\$55,803,000	\$27,901,500	-\$5,516,000	-\$2,758,000	-\$2,847,000	-\$1,423,500
59	SENIOR CARE ACTION NETWORK (Other M/C)	\$44,643,000	\$22,321,500	\$38,880,000	\$19,440,000	\$35,284,000	\$17,642,000	-\$9,359,000	-\$4,679,500	-\$3,596,000	-\$1,798,000
62	AIDS HEALTHCARE CENTERS (Other M/C)	\$10,926,000	\$5,463,000	\$11,766,000	\$5,883,000	\$12,354,000	\$6,177,000	\$1,428,000	\$714,000	\$588,000	\$294,000
63	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,681,000	\$1,340,500	\$2,681,000	\$1,340,500	\$2,887,000	\$1,443,500	\$206,000	\$103,000	\$206,000	\$103,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$8,676,642,000</b>	<b>\$4,332,920,700</b>	<b>\$9,799,142,000</b>	<b>\$4,880,734,500</b>	<b>\$10,576,543,000</b>	<b>\$5,268,621,000</b>	<b>\$1,899,901,000</b>	<b>\$935,700,300</b>	<b>\$777,401,000</b>	<b>\$387,886,500</b>
<b>OTHER</b>											
128	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,681,853,000	\$0	\$2,816,230,000	\$0	\$2,697,785,000	\$0	\$15,932,000	\$0	-\$118,445,000	\$0
129	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,591,047,000	\$1,380,533,500	\$2,507,022,000	\$1,334,302,500	\$2,477,512,000	\$1,321,763,000	-\$113,535,000	-\$58,770,500	-\$29,510,000	-\$12,539,500
130	MENTAL HEALTH SERVICES-CDMH	\$1,562,519,000	\$0	\$1,562,519,000	\$0	\$1,228,325,000	\$0	-\$334,194,000	\$0	-\$334,194,000	\$0
131	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,396,673,000	\$1,396,673,000	\$1,402,104,000	\$1,402,104,000	\$1,400,152,000	\$1,400,152,000	\$3,479,000	\$3,479,000	-\$1,952,000	-\$1,952,000
132	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,013,784,000	\$0	\$1,041,263,000	\$0	\$1,115,755,000	\$0	\$101,971,000	\$0	\$74,492,000	\$0
134	DENTAL SERVICES	\$563,338,000	\$278,060,150	\$487,319,000	\$240,059,350	\$482,799,000	\$237,771,900	-\$80,539,000	-\$40,288,250	-\$4,520,000	-\$2,287,450
135	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$235,701,000	\$0	\$269,464,000	\$0	\$262,857,000	\$0	\$27,156,000	\$0	-\$6,607,000	\$0
137	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$150,840,000	\$0	\$147,567,000	\$0	\$148,553,000	\$0	-\$2,287,000	\$0	\$986,000	\$0
138	DRUG MEDI-CAL-CDADP	\$114,747,000	\$0	\$112,599,000	\$0	\$58,670,000	\$0	-\$56,077,000	\$0	-\$53,929,000	\$0
139	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$56,067,000	\$0	\$62,445,000	\$0	\$59,617,000	\$0	\$3,550,000	\$0	-\$2,828,000	\$0
140	EPSDT SCREENS	\$58,838,000	\$29,419,000	\$50,030,000	\$25,015,000	\$52,096,000	\$26,048,000	-\$6,742,000	-\$3,371,000	\$2,066,000	\$1,033,000
141	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$36,819,000	\$18,409,500	\$38,125,000	\$19,062,500	\$35,510,000	\$17,755,000	-\$1,309,000	-\$654,500	-\$2,615,000	-\$1,307,500
144	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$9,354,000	\$4,677,000	\$11,354,000	\$5,677,000	\$9,489,000	\$4,744,500	\$2,000,000	\$1,000,000
149	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$3,297,000	\$1,648,500	\$2,485,000	\$1,242,500	\$2,414,000	\$1,207,000	-\$883,000	-\$441,500	-\$71,000	-\$35,500
150	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$0	\$1,503,000	\$0	\$1,503,000	\$0	\$475,000	\$0	\$0	\$0
164	BASE RECOVERIES	-\$287,108,000	-\$172,265,000	-\$301,641,000	-\$180,532,000	-\$265,809,000	-\$159,087,000	\$21,299,000	\$13,178,000	\$35,832,000	\$21,445,000
	<b>OTHER SUBTOTAL</b>	<b>\$10,181,308,000</b>	<b>\$2,933,411,150</b>	<b>\$10,208,388,000</b>	<b>\$2,845,930,850</b>	<b>\$9,769,093,000</b>	<b>\$2,851,286,900</b>	<b>-\$412,215,000</b>	<b>-\$82,124,250</b>	<b>-\$439,295,000</b>	<b>\$5,356,050</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2012 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2011 ESTIMATE  
FISCAL YEAR 2011-12**

NO.	POLICY CHANGE TITLE	2011-12 APPROPRIATION		NOV. 2011 EST. FOR 2011-12		MAY 2012 EST. FOR 2011-12		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>GRAND TOTAL</b>	<b>\$18,857,950,000</b>	<b>\$7,266,331,850</b>	<b>\$20,007,530,000</b>	<b>\$7,726,665,350</b>	<b>\$20,345,636,000</b>	<b>\$8,119,907,900</b>	<b>\$1,487,686,000</b>	<b>\$853,576,050</b>	<b>\$338,106,000</b>	<b>\$393,242,550</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2012 ESTIMATE COMPARED TO NOVEMBER 2011 ESTIMATE  
FISCAL YEAR 2012-13**

NO.	POLICY CHANGE TITLE	NOV. 2011 EST. FOR 2012-13		MAY 2012 EST. FOR 2012-13		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>							
52	TWO PLAN MODEL	\$5,296,537,000	\$2,635,831,100	\$6,734,508,000	\$3,353,388,800	\$1,437,971,000	\$717,557,700
53	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,606,810,000	\$1,797,909,900	\$3,622,780,000	\$1,804,900,500	\$15,970,000	\$6,990,600
54	GEOGRAPHIC MANAGED CARE	\$891,354,000	\$443,497,800	\$1,147,888,000	\$571,449,400	\$256,534,000	\$127,951,600
57	PACE (Other M/C)	\$190,602,000	\$95,301,000	\$175,408,000	\$87,704,000	-\$15,194,000	-\$7,597,000
58	DENTAL MANAGED CARE (Other M/C)	\$59,957,000	\$29,978,500	\$54,807,000	\$27,403,500	-\$5,150,000	-\$2,575,000
59	SENIOR CARE ACTION NETWORK (Other M/C)	\$44,247,000	\$22,123,500	\$14,944,000	\$7,472,000	-\$29,303,000	-\$14,651,500
62	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,642,000	\$6,321,000	\$14,157,000	\$7,078,500	\$1,515,000	\$757,500
63	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,681,000	\$1,340,500	\$2,887,000	\$1,443,500	\$206,000	\$103,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$10,104,830,000</b>	<b>\$5,032,303,300</b>	<b>\$11,767,379,000</b>	<b>\$5,860,840,200</b>	<b>\$1,662,549,000</b>	<b>\$828,536,900</b>
<b>OTHER</b>							
128	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,908,267,000	\$0	\$2,525,036,000	\$0	-\$383,231,000	\$0
129	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,518,501,000	\$1,338,859,000	\$2,485,702,000	\$1,324,429,000	-\$32,799,000	-\$14,430,000
130	MENTAL HEALTH SERVICES-CDMH	\$1,562,519,000	\$0	\$1,677,313,000	\$0	\$114,794,000	\$0
131	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,474,851,000	\$1,474,851,000	\$1,465,483,000	\$1,465,483,000	-\$9,368,000	-\$9,368,000
132	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$998,266,000	\$0	\$1,089,699,000	\$0	\$91,433,000	\$0
134	DENTAL SERVICES	\$528,446,000	\$260,622,850	\$526,115,000	\$259,429,900	-\$2,331,000	-\$1,192,950
135	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$213,498,000	\$0	\$205,349,000	\$0	-\$8,149,000	\$0
137	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$138,466,000	\$0	\$138,469,000	\$0	\$3,000	\$0
138	DRUG MEDI-CAL-CDADP	\$125,254,000	\$0	\$154,869,000	\$0	\$29,615,000	\$0
139	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$59,256,000	\$0	\$57,621,000	\$0	-\$1,635,000	\$0
140	EPSDT SCREENS	\$49,030,000	\$24,515,000	\$53,242,000	\$26,621,000	\$4,212,000	\$2,106,000
141	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$46,952,000	\$23,476,000	\$38,751,000	\$19,375,500	-\$8,201,000	-\$4,100,500
144	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$1,865,000	\$932,500	\$0	\$0
149	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,713,000	\$856,500	\$1,471,000	\$735,500	-\$242,000	-\$121,000
150	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$0	\$1,028,000	\$0	\$0	\$0
164	BASE RECOVERIES	-\$303,758,000	-\$181,799,000	-\$266,256,000	-\$159,354,000	\$37,502,000	\$22,445,000
	<b>OTHER SUBTOTAL</b>	<b>\$10,324,154,000</b>	<b>\$2,942,313,850</b>	<b>\$10,155,757,000</b>	<b>\$2,937,652,400</b>	<b>-\$168,397,000</b>	<b>-\$4,661,450</b>
	<b>GRAND TOTAL</b>	<b>\$20,428,984,000</b>	<b>\$7,974,617,150</b>	<b>\$21,923,136,000</b>	<b>\$8,798,492,600</b>	<b>\$1,494,152,000</b>	<b>\$823,875,450</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2011-12 AND 2012-13**

NO.	POLICY CHANGE TITLE	MAY 2012 EST. FOR 2011-12		MAY 2012 EST. FOR 2012-13		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>							
52	TWO PLAN MODEL	\$5,827,565,000	\$2,901,734,800	\$6,734,508,000	\$3,353,388,800	\$906,943,000	\$451,654,000
53	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,507,033,000	\$1,748,165,300	\$3,622,780,000	\$1,804,900,500	\$115,747,000	\$56,735,200
54	GEOGRAPHIC MANAGED CARE	\$989,876,000	\$492,686,400	\$1,147,888,000	\$571,449,400	\$158,012,000	\$78,763,000
57	PACE (Other M/C)	\$145,741,000	\$72,870,500	\$175,408,000	\$87,704,000	\$29,667,000	\$14,833,500
58	DENTAL MANAGED CARE (Other M/C)	\$55,803,000	\$27,901,500	\$54,807,000	\$27,403,500	-\$996,000	-\$498,000
59	SENIOR CARE ACTION NETWORK (Other M/C)	\$35,284,000	\$17,642,000	\$14,944,000	\$7,472,000	-\$20,340,000	-\$10,170,000
62	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,354,000	\$6,177,000	\$14,157,000	\$7,078,500	\$1,803,000	\$901,500
63	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,887,000	\$1,443,500	\$2,887,000	\$1,443,500	\$0	\$0
<b>MANAGED CARE SUBTOTAL</b>		<b>\$10,576,543,000</b>	<b>\$5,268,621,000</b>	<b>\$11,767,379,000</b>	<b>\$5,860,840,200</b>	<b>\$1,190,836,000</b>	<b>\$592,219,200</b>
<b>OTHER</b>							
128	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,697,785,000	\$0	\$2,525,036,000	\$0	-\$172,749,000	\$0
129	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,477,512,000	\$1,321,763,000	\$2,485,702,000	\$1,324,429,000	\$8,190,000	\$2,666,000
130	MENTAL HEALTH SERVICES-CDMH	\$1,228,325,000	\$0	\$1,677,313,000	\$0	\$448,988,000	\$0
131	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,400,152,000	\$1,400,152,000	\$1,465,483,000	\$1,465,483,000	\$65,331,000	\$65,331,000
132	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,115,755,000	\$0	\$1,089,699,000	\$0	-\$26,056,000	\$0
134	DENTAL SERVICES	\$482,799,000	\$237,771,900	\$526,115,000	\$259,429,900	\$43,316,000	\$21,658,000
135	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$262,857,000	\$0	\$205,349,000	\$0	-\$57,508,000	\$0
137	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$148,553,000	\$0	\$138,469,000	\$0	-\$10,084,000	\$0
138	DRUG MEDI-CAL-CDADP	\$58,670,000	\$0	\$154,869,000	\$0	\$96,199,000	\$0
139	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$59,617,000	\$0	\$57,621,000	\$0	-\$1,996,000	\$0
140	EPSDT SCREENS	\$52,096,000	\$26,048,000	\$53,242,000	\$26,621,000	\$1,146,000	\$573,000
141	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$35,510,000	\$17,755,000	\$38,751,000	\$19,375,500	\$3,241,000	\$1,620,500
144	LAWSUITS/CLAIMS	\$11,354,000	\$5,677,000	\$1,865,000	\$932,500	-\$9,489,000	-\$4,744,500
149	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,414,000	\$1,207,000	\$1,471,000	\$735,500	-\$943,000	-\$471,500
150	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,503,000	\$0	\$1,028,000	\$0	-\$475,000	\$0
164	BASE RECOVERIES	-\$265,809,000	-\$159,087,000	-\$266,256,000	-\$159,354,000	-\$447,000	-\$267,000
<b>OTHER SUBTOTAL</b>		<b>\$9,769,093,000</b>	<b>\$2,851,286,900</b>	<b>\$10,155,757,000</b>	<b>\$2,937,652,400</b>	<b>\$386,664,000</b>	<b>\$86,365,500</b>

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 2011-12 AND 2012-13**

NO.	POLICY CHANGE TITLE	MAY 2012 EST. FOR 2011-12		MAY 2012 EST. FOR 2012-13		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>GRAND TOTAL</b>	<b>\$20,345,636,000</b>	<b>\$8,119,907,900</b>	<b>\$21,923,136,000</b>	<b>\$8,798,492,600</b>	<b>\$1,577,500,000</b>	<b>\$678,584,700</b>

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**

52	TWO PLAN MODEL
53	COUNTY ORGANIZED HEALTH SYSTEMS
54	GEOGRAPHIC MANAGED CARE
57	PACE (Other M/C)
58	DENTAL MANAGED CARE (Other M/C)
59	SENIOR CARE ACTION NETWORK (Other M/C)
62	AIDS HEALTHCARE CENTERS (Other M/C)
63	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)

**OTHER**

128	PERSONAL CARE SERVICES (Misc. Svcs.)
129	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
130	MENTAL HEALTH SERVICES-CDMH
131	MEDICARE PAYMENTS - PART D PHASED-DOWN
132	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)
134	DENTAL SERVICES
135	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
137	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
138	DRUG MEDI-CAL-CDADP
139	MEDI-CAL TCM PROGRAM (Misc. Svcs.)
140	EPSDT SCREENS
141	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
144	LAWSUITS/CLAIMS
149	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
150	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)
164	BASE RECOVERIES

## TWO PLAN MODEL

**BASE POLICY CHANGE NUMBER:** 52  
**IMPLEMENTATION DATE:** 7/2000  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 56

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$5,827,565,000	\$6,734,508,000
- STATE FUNDS	\$2,901,734,800	\$3,353,388,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,827,565,000	\$6,734,508,000
STATE FUNDS	\$2,901,734,800	\$3,353,388,800
FEDERAL FUNDS	\$2,925,830,200	\$3,381,119,200

### DESCRIPTION

#### Purpose

This policy change estimates the managed care capitation costs for the Two-Plan model.

#### Authority:

Welfare and Institutions Code, section 14087.3

#### Background:

Under the Two-Plan model, each designated county has two managed care plans, a local initiative and a commercial plan, which provides medically necessary services to Medi-Cal beneficiaries residing within the county. There are 14 counties in the Two Plan Model: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. In March 2011, a regional Two-Plan Model for Fresno, Kings and Madera Counties was implemented.

#### Reason for Change from Prior Estimate:

Transition of Seniors and Persons with Disabilities to Medi-Cal Managed Care.

#### Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends
2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.

## TWO PLAN MODEL

### BASE POLICY CHANGE NUMBER: 52

3. The FY 2011-12 and FY 2012-13 rates include:
  - Annual rate redeterminations for FY 2012-13
  - Pharmacy rate adjustment, which evaluates pharmacy pricing and adjusts for avoidable costs
4. AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change.
5. Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of MCO Tax to General Fund policy change.
6. The FY 2011-12 and FY 2012-13 family planning is budgeted at a Federal Medical Assistance Percentage (FMAP) split of 90/10 in the managed care model policy changes.

(Dollars in Thousands)	Eligible Months	Total
<b>FY 2011-12</b>		
Alameda	1,841,398	\$373,138
Contra Costa	1,025,183	\$204,507
Kern	1,852,439	\$269,089
Los Angeles	17,200,136	\$2,369,836
Riverside	3,163,164	\$474,379
San Bernardino	3,701,205	\$543,108
San Francisco	780,495	\$169,045
San Joaquin	1,468,664	\$231,408
Santa Clara	1,780,031	\$294,716
Stanislaus	980,577	\$169,876
Tulare	1,391,443	\$196,638
Fresno	2,684,732	\$441,147
Kings	287,174	\$43,125
Madera	347,299	\$47,553
<b>Total FY 2011-12</b>	<b>38,503,940</b>	<b>\$5,827,565</b>

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 52**

<b>FY 2012-13</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	2,009,343	\$422,456
Contra Costa	1,116,033	\$233,100
Kern	1,955,151	\$296,013
Los Angeles	18,204,471	\$2,805,253
Riverside	3,374,087	\$535,145
San Bernardino	3,955,650	\$617,624
San Francisco	877,531	\$228,066
San Joaquin	1,566,269	\$267,229
Santa Clara	1,901,720	\$334,683
Stanislaus	1,038,563	\$202,122
Tulare	1,449,250	\$221,748
Fresno	2,749,422	\$470,557
Kings	298,020	\$48,230
Madera	357,930	\$52,282
<b>Total FY 2012-13</b>	<b>40,853,440</b>	<b>\$6,734,508</b>

**Funding:**

(in Thousands)

**FY 2011-12:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$2,872,587	\$2,872,588	<b>\$5,745,173</b>
State GF	4260-101-0001	\$23,237		<b>\$23,237</b>
Family Planning 90/10 GF	4260-101-0001/0890	\$5,911	\$53,202	<b>\$59,113</b>
ARRA 100% FFP	4260-101-0890		\$42	<b>\$42</b>

**FY 2012-13:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$3,325,996	\$3,325,996	<b>\$6,651,992</b>
State GF	4260-101-0001	\$21,268		<b>\$21,268</b>
Family Planning 90/10 GF	4260-101-0001/0890	\$6,125	\$55,123	<b>\$61,248</b>

## COUNTY ORGANIZED HEALTH SYSTEMS

**BASE POLICY CHANGE NUMBER:** 53  
**IMPLEMENTATION DATE:** 12/1987  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 57

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$3,507,033,000	\$3,622,780,000
- STATE FUNDS	\$1,748,165,300	\$1,804,900,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,507,033,000	\$3,622,780,000
STATE FUNDS	\$1,748,165,300	\$1,804,900,500
FEDERAL FUNDS	\$1,758,867,700	\$1,817,879,500

### DESCRIPTION

**Purpose:**

This policy change estimates the managed care capitation costs for the County Organized Health Systems (COHS) model.

**Authority:**

Welfare and Institutions Code, section 14087.3

**Background:**

A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 14 counties in the COHS Model: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Solano, Sonoma, Ventura, and Yolo. In July 2011, COHS expanded into Marin, Mendocino, and Ventura Counties.

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.
2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.
3. Currently, all COHS plans have assumed risk for long term care services. 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, 2013.

## COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 53

4. The FY 2011-12 and FY 2012-13 rates include:
  - Annual rate redeterminations for FY 2012-13.
  - Pharmacy rate adjustment, which evaluates pharmacy pricing and adjusts for avoidable costs.
  
5. AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. The Department has proposed trailer bill language that will eliminate the sunset date for the gross premium tax on the total operating revenue for the Medi-Cal managed care plans. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change. For additional information on the gross premium tax extension, see the Extend Gross Premium Tax – Incr. Capitation Rates and the Extend Gross Premium Tax-Funding Adjustment policy changes.
  
6. Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of MCO Tax to General Fund policy change.
  
7. The FY 2011-12 and FY 2012-13 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

(Dollars in Thousands) FY 2011-12	Eligible Months	Total
San Luis Obispo	353,447	\$97,746
CalOPTIMA(Orange)	4,627,990	\$1,211,467
Monterey	907,651	\$223,938
Napa	176,691	\$58,057
San Mateo	754,636	\$342,566
Santa Barbara	781,969	\$211,029
Santa Cruz	427,530	\$123,062
Solano	757,780	\$229,404
Yolo	330,571	\$99,741
Sonoma	656,163	\$224,872
Merced	898,822	\$213,888
Marin	209,471	\$88,751
Mendocino	244,748	\$80,004
Ventura	1,244,868	\$302,508
<b>Total FY 2011-12</b>	<b>12,372,337</b>	<b>\$3,507,033</b>

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 53

(Dollars in Thousands) <b>FY 2012-13</b>	<b>Eligible Months</b>	<b>Total</b>
San Luis Obispo	359,248	\$103,658
CalOPTIMA(Orange)	4,793,519	\$1,252,552
Monterey	959,331	\$240,048
Napa	184,579	\$59,701
San Mateo	780,553	\$352,529
Santa Barbara	799,177	\$224,959
Santa Cruz	433,857	\$126,567
Solano	776,068	\$247,819
Yolo	339,135	\$103,964
Sonoma	672,498	\$220,789
Merced	918,642	\$227,677
Marin	208,479	\$91,862
Mendocino	245,753	\$82,061
Ventura	1,233,675	\$288,594
<b>Total FY 2012-13</b>	<b>12,704,514</b>	<b>\$3,622,780</b>

**Funding: (In Thousands)****FY 2011-12:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$1,741,247	\$1,741,247	<b>\$3,482,494</b>
State GF	4260-101-0001	\$4,960		<b>\$4,960</b>
Family Planning 90/10 GF	4260-101-0001/0890	\$1,958	\$17,620	<b>\$19,578</b>

**FY 2012-13:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$1,799,623	\$1,799,623	<b>\$3,599,246</b>
State GF	4260-101-0001	\$3,249		<b>\$3,249</b>
Family Planning 90/10 GF	4260-101-0001/0890	\$2,029	\$18,256	<b>\$20,285</b>

## GEOGRAPHIC MANAGED CARE

**BASE POLICY CHANGE NUMBER:** 54  
**IMPLEMENTATION DATE:** 4/1994  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 58

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$989,876,000	\$1,147,888,000
- STATE FUNDS	\$492,686,400	\$571,449,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$989,876,000	\$1,147,888,000
STATE FUNDS	\$492,686,400	\$571,449,400
FEDERAL FUNDS	\$497,189,600	\$576,438,600

### DESCRIPTION

**Purpose:**

This policy change estimates the managed care capitation costs for the Geographic Managed Care (GMC) model plans.

**Authority:**

Welfare & Institutions Code, section 14087.3

**Background:**

There are two counties in the GMC model: Sacramento and San Diego. In both counties, the Department contracts with several commercial plans providing more choices for the beneficiaries.

**Reason for Change from Prior Estimate:**

Transition of Seniors and Persons with Disabilities to Medi-Cal Managed Care.

**Methodology:**

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.
2. The GMC program requires mandatory enrollment for most of Public Assistance, Medically Needy, Medically Indigent Children, Refugee beneficiaries, and Poverty aid codes. Beneficiaries that are able to voluntarily enroll include aid codes for Family, Disabled, Aged, and Breast and Cervical Cancer Treatment (BCCTP). Mandatory enrollment for Seniors and Persons with Disabilities (SPDs) was implemented June 1, 2011.
3. The FY 2011-12 and FY 2012-13 rates include:
  - Annual rate redeterminations for FY 2012-13
  - Pharmacy rate adjustment, which evaluates pharmacy pricing and adjusts for avoidable costs

**GEOGRAPHIC MANAGED CARE****BASE POLICY CHANGE NUMBER: 54**

4. AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. The Administration is proposing legislation to eliminate the sunset date on the gross premium tax on the total operating revenue for the Medi-Cal Managed Care plans. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change. For additional information on the gross premium tax extension see policy change Extend Gross Premium Tax – Incr. Capitation Rates and Extend Gross Premium Tax – Funding Adjustment.
5. Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of MCO Tax to General Fund policy change.
6. The FY 2011-12 and FY 2012-13 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

(Dollars in Thousands)

<b>FY 2011-12</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento GMC	2,649,693	\$449,049
San Diego GMC	3,144,627	\$540,827
<b>Total FY 2011-12</b>	<b>5,794,320</b>	<b>\$989,876</b>
<b>FY 2012-13</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento GMC	2,829,898	\$509,663
San Diego GMC	3,390,210	\$638,225
<b>Total FY 2012-13</b>	<b>6,220,108</b>	<b>\$1,147,888</b>

**Funding:**

(In Thousands)

**FY 2011-12:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$488,330	\$488,330	<b>\$976,660</b>
State GF	4260-101-0001	\$3,372	\$0	<b>\$3,372</b>
Family Planning 90/10 FFP	4260-101-0001/0890	\$984	\$8,860	<b>\$9,844</b>

**FY 2012-13:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$567,259	\$567,259	<b>\$1,134,519</b>
State GF	4260-101-0001	\$3,170		<b>\$3,170</b>
Family Planning 90/10 FFP	4260-101-0001/0890	\$1,020	\$9,179	<b>\$10,199</b>

## PACE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 57  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 62

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$145,741,000	\$175,408,000
- STATE FUNDS	\$72,870,500	\$87,704,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$145,741,000	\$175,408,000
STATE FUNDS	\$72,870,500	\$87,704,000
FEDERAL FUNDS	\$72,870,500	\$87,704,000

### DESCRIPTION

**Purpose:**

This policy change estimates the capitation payments under the Program of All-Inclusive Care for the Elderly (PACE).

**Authority:**

Welfare and Institutions Code, sections 14591-14593  
Balanced Budget Act of 1997 (BBA)

**Background:**

The PACE program is a capitated benefit that provides a comprehensive medical/social delivery system. Services are provided in a PACE center to older adults who would otherwise reside in nursing facilities. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department, and be able to live safely in their home or community at the time of enrollment. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

The Department currently has five contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. Six new PACE organizations will begin operation in FY 2012-13. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

**Reason for Change from Prior Estimate:**

Implementation dates for the new PACE organizations was delayed due to departmental staffing issues.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 57**

Below is a list of PACE organizations:

<u>PACE Organization</u>	<u>County</u>	<u>Operational</u>
On Lok Lifeways	San Francisco Alameda Santa Clara	November 1, 1983 July 1, 2002 January 1, 2009
Centers for Elders Independence	Alameda	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
Alta Med Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE- (Community Elder Care of San Diego)	San Diego	February 1, 2009
Cal Optima	Orange	September 1, 2012
Brandman (LA Jewish Home)	Los Angeles	September 1, 2012
Total Long-Term Care	San Bernardino	April 1, 2013
PACE of the Desert	Riverside	January 1, 2013
SCAN	Los Angeles	February 1, 2013
Humboldt Senior Resource Center	Humboldt	March 1, 2013

**Methodology:**

1. Assume the 2011 rates are calculated using the Upper Payment Limit (UPL) for each year including 2011. The 2012 and 2013 rate setting methodology will use a mix of IHSS and long-term care facility actual cost-based data.
2. FY 2011-12 and FY 2012-13 estimated funding is based on FYs 2010-11 and 2011-12 proposed rates effective 1/1/13. Rates for the new PACE organizations have not yet been developed, therefore for the purposes for this budget, weighted average rates are used.
3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 57**

<b>FY 2011-12</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Average Monthly Enrollment</b>
Center for Elders			
Independence	\$27,106,000	6,096	508
Sutter Senior Care	\$9,552,000	2,631	219
Alta Med Senior BuenaCare	\$41,124,000	10,846	904
On Lok Lifeways	\$59,763,000	13,343	1,112
St. Paul's PACE (CESD)	\$8,196,000	2,177	181
<b>Total Capitation Payments</b>	<b>\$145,741,000</b>	<b>35,093</b>	<b>2,924</b>
<b>FY 2012-13</b>			
Center for Elders			
Independence	\$28,019,000	6,397	533
Sutter Senior Care	\$10,016,000	2,776	231
Alta Med Senior BuenaCare	\$49,764,000	13,282	1,107
On Lok Lifeways	\$62,839,000	13,925	1,160
St. Paul's PACE (CESD)	\$19,070,000	5,028	419
Brandman (LAJH)	\$1,545,000	377	31
Cal Optima	\$1,766,000	422	35
Total Long-Term Care	\$674,000	165	14
PACE of the Desert	\$466,000	117	10
SCAN	\$979,000	240	20
Humboldt Senior Resource Center	\$270,000	66	6
<b>Total Capitation Payments</b>	<b>\$175,408,000</b>	<b>42,795</b>	<b>3,566</b>

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

**DENTAL MANAGED CARE (Other M/C)**

**BASE POLICY CHANGE NUMBER:** 58  
**IMPLEMENTATION DATE:** 7/2004  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1029

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$55,803,000</b>	<b>\$54,807,000</b>
<b>- STATE FUNDS</b>	<b>\$27,901,500</b>	<b>\$27,403,500</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$55,803,000</b>	<b>\$54,807,000</b>
<b>STATE FUNDS</b>	<b>\$27,901,500</b>	<b>\$27,403,500</b>
<b>FEDERAL FUNDS</b>	<b>\$27,901,500</b>	<b>\$27,403,500</b>

**DESCRIPTION****Purpose:**

The policy change estimates the cost of dental capitation rates for the Dental Managed Care (DMC) program.

**Authority:**

Social Security Act, Title XIX

**Background:**

The DMC program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. The Department contracts with five Geographic Managed Care (GMC) plans and eight Prepaid Health Plans (PHP) for providing dental services to Medi-Cal beneficiaries in Sacramento, Los Angeles, Riverside, and San Bernardino counties.

Each dental plan receives a negotiated monthly per capita rate from the state for every recipient enrolled in their plan. DMC program recipients enrolled in contracting plans are entitled to receive dental benefits from dentists within the plan's provider network.

**Reason for Change from Prior Estimate:**

New rates, to be effective January 1, 2012.

**Methodology:**

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.
2. The retroactive adjustments of the rates from July 2009 to February 2011 are shown in the Dental Retroactive Rates changes policy change.
3. Dental rates for the Senior Care Action Network (SCAN) and the Program of All-Inclusive Care for the Elderly (PACE) are incorporated into the SCAN and PACE policy changes.

**DENTAL MANAGED CARE (Other M/C)**

BASE POLICY CHANGE NUMBER: 58

4. No rate adjustments have been included for FY 2012-13. The prior period rates have been used.

<b>FY 2011-12</b>	<b>Capitation Rate</b>	<b>Average Monthly Eligibles</b>	<b>Total Funds</b>
July 2011 – Dec 2011			
GMC			
<21	\$11.83	69,156	\$9,817,000
21+	\$2.91	37,344	\$1,304,000
PHP			
<21	\$11.83	114,308	\$16,227,000
21+	\$2.91	40,900	\$1,428,000
			<u>\$28,776,000</u>
Jan 2012 – June 2012			
GMC			
<21	\$11.46	70,145	\$9,646,000
21+	\$1.45	37,878	\$659,000
PHP			
<21	\$11.46	116,278	\$15,990,000
21+	\$1.45	42,048	\$732,000
			<u>\$27,027,000</u>
<b>Total</b>			<b>\$55,803,000</b>
<b>FY 2012-13</b>			
GMC			
<21	\$11.46	142,060	\$19,536,000
21+	\$1.45	76,711	\$1,335,000
PHP			
<21	\$11.46	236,079	\$32,466,000
21+	\$1.45	84,470	\$1,470,000
			<u>\$54,807,000</u>
<b>Total</b>			<b>\$54,807,000</b>

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

## SENIOR CARE ACTION NETWORK (Other M/C)

**BASE POLICY CHANGE NUMBER:** 59  
**IMPLEMENTATION DATE:** 2/1985  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 61

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$35,284,000	\$14,944,000
- STATE FUNDS	\$17,642,000	\$7,472,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$35,284,000	\$14,944,000
STATE FUNDS	\$17,642,000	\$7,472,000
FEDERAL FUNDS	\$17,642,000	\$7,472,000

### DESCRIPTION

**Purpose:**

This policy change estimates the capitated payments associated with enrollment of dual eligible Medicare/Medi-Cal beneficiaries in the Senior Care Action Network (SCAN) health plan.

**Authority:**

Welfare and Institutions Code, section 14200

**Background:**

SCAN is a Medicare Advantage Special Needs Plan and contracts with the Department to coordinate and provide health care services on a capitated basis for persons aged 65 and older with both Medicare and Medi-Cal coverage in Los Angeles, San Bernardino, and Riverside Counties. SCAN operates as a social health maintenance organization under special waivers and has held a contract with the Centers for Medicare and Medicaid Services (CMS) since 1985. Enrollees who are certified for Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) level of care are eligible for additional Home and Community Based Services (HCBS) through the SCAN Health Plan Independent Living Power program.

**Reason for Change from Prior Estimate:**

The estimated costs for FY 2011-12 have changed based on a reduction in caseload. The estimated costs for FY 2012-13 include a recoupment from SCAN.

**Methodology:**

1. Estimated SCAN costs are computed by multiplying the actual and estimated monthly eligible count for each county times the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.
2. Total enrollment is projected to be 7,404 in June 2012 and 7,529 by June 2013 based on certified Medi-Cal eligibles data.

**SENIOR CARE ACTION NETWORK (Other M/C)**

BASE POLICY CHANGE NUMBER: 59

3. Rates for 2009 dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. Rates for 2009 were determined by comparing nursing home eligible participants cost data for Multipurpose Senior Services Program (MSSP) and SCAN's bid. The rates for 2010 have not been finalized. Therefore, FY 2011-12 and FY 2012-13 rates are based on preliminary rates. Rates in development will be based on SCAN plans' actual experience.
4. AB 1422 (Chapter 157, Statutes of 2009) imposes a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax are used to offset the capitation rates. AB 1422 has been extended through June 30, 2012. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax from AB 1422 is included in the Increase in Capitation Rates for Gross Premium Tax policy change.
5. Through a departmental medical audit, individuals who were ineligible for SCAN benefits were enrolled during the periods of May 1, 2008 through December 31, 2008 and January 1, 2009 through December 31, 2009. SCAN will repay the Department for those costs. The Department expects recoupment in FY 2012-13.

<b>FY 2011-12</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Average Monthly Enrollment</b>
Los Angeles	\$23,073,000	57,154	4,763
Riverside	\$7,964,000	19,452	1,621
San Bernardino	\$4,247,000	11,639	970
<b>Total Capitation Payments</b>	<b>\$35,284,000</b>	88,245	7,354
<b>FY 2012-13</b>			
Los Angeles	\$23,424,000	58,024	4,835
Riverside	\$8,018,000	19,584	1,632
San Bernardino	\$4,403,000	12,066	1,006
Total Capitation Payments	\$35,845,000	89,674	7,473
Recoupment	-\$20,901,000		
<b>Total</b>	<b>\$14,944,000</b>		

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

## AIDS HEALTHCARE CENTERS (Other M/C)

**BASE POLICY CHANGE NUMBER:** 62  
**IMPLEMENTATION DATE:** 5/1985  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 63

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$12,354,000	\$14,157,000
- STATE FUNDS	\$6,177,000	\$7,078,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,354,000	\$14,157,000
STATE FUNDS	\$6,177,000	\$7,078,500
FEDERAL FUNDS	\$6,177,000	\$7,078,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of capitation rates and the savings sharing for AIDS Healthcare centers.

**Authority:**

Welfare & Institutions Code, section 14088.85

**Background:**

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with the PCCM plan to participate in a program savings sharing agreement. Shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department has determined that there are no shared savings for calendar year (CY) 2009. The shared savings for CY 2010 and beyond have not yet been determined. On January 1, 2012, the Department entered into a new five year contract with AIDS Healthcare Foundation.

AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 has extended the gross premium tax through June 30, 2012. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of MCO Tax to General Fund policy change.

**Reason for Change from Prior Estimate:**

Revised based on updated eligibles.

**AIDS HEALTHCARE CENTERS (Other M/C)**

BASE POLICY CHANGE NUMBER: 62

**Methodology:**

1. Assume in FY 2011-12 dual eligible months will be 4,645 and 5,322 in FY 2012-13.
2. Assume in FY 2011-12 Medi-Cal only eligible months will be 6,029 and 6,908 in FY 2012-13.
3. Dual capitation rates are assumed to be \$272.23 for FY 2011-12 and FY 2012-13.
4. Medi-Cal only capitation rates are assumed to be \$1,839.50 for FY 2011-12 and FY 2012-13.

## Duals:

FY 11/12: 4,645 x \$272.23 = \$1,264,000

FY 12/13: 5,322 x \$272.23 = \$1,449,000

## Medi-Cal Only:

FY 11/12: 6,029 x \$1,839.50 = \$11,090,000

FY 12/13: 6,908 x \$1,839.50 = \$12,708,000

	<u>FY 11/12</u>	<u>FY 12/13</u>
Dual	\$ 1,264,000	\$ 1,449,000
Medi-Cal Only	\$11,090,000	\$12,708,000
<b>Total (Rounded)</b>	<b>\$12,354,000</b>	<b>\$14,157,000</b>

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

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

**BASE POLICY CHANGE NUMBER:** 63  
**IMPLEMENTATION DATE:** 3/1993  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 66

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$2,887,000	\$2,887,000
- STATE FUNDS	\$1,443,500	\$1,443,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,887,000	\$2,887,000
STATE FUNDS	\$1,443,500	\$1,443,500
FEDERAL FUNDS	\$1,443,500	\$1,443,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of the contract with the Family Mosaic project.

**Authority:**

Welfare and Institutions Code, section 14087.3

**Background:**

The Department's contract with the Family Mosaic Project is effective January 1, 2008 through December 31, 2013. The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out of home placement.

**Reason for Change from Previous Estimate:**

Updated caseload data.

**Methodology:**

1. It is assumed the annual member months will be 1,562 for FY 2011-12 and FY 2012-13.
2. The FY 2011-12 and FY 2012-13 Family Mosaic capitation rates are assumed to be \$1,848.75.
3. The FY 2011-12 and FY 2012-13 costs for the Family Mosaic Project are expected to be:

FY 2011 - 12: 1,562 x \$1,848.75 = **\$2,887,000 TF (\$1,443,500 GF)**

FY 2012 - 13: 1,562 x \$1,848.75 = **\$2,887,000 TF (\$1,443,500 GF)**

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

## PERSONAL CARE SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 128  
**IMPLEMENTATION DATE:** 4/1993  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 22

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$2,697,785,000</b>	<b>\$2,525,036,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$2,697,785,000</b>	<b>\$2,525,036,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$2,697,785,000</b>	<b>\$2,525,036,000</b>

### DESCRIPTION

**Purpose:**

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal beneficiaries participating in the In-Home Supportive Services (IHSS) Personal Care Services Program (PCSP) and the Independence Plus Option (IPO) administered by CDSS. This policy change budgets the FFP for these services.

**Authority:**

Interagency Agreement

**Background:**

Title XIX eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS via interagency agreements (IA) 03-75676 for the IHSS PCSP and IA 09-86307 for the IPO.

Legislation is being proposed to mandatorily enroll dual eligible into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change Transition of Dual Eligibles-LTC for more information. IHSS costs are currently budgeted in this policy change, but due to the transitions of IHSS recipients to managed care, IHSS costs will be paid through managed care capitation beginning March 1, 2013. IHSS cost related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.

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.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2011-12. Services paid by the CDSS between October 1, 2008 and June 30, 2011, billed to the Department in FY 2011-12 are eligible to receive the increased FMAP.

**PERSONAL CARE SERVICES (Misc. Svcs.)**

BASE POLICY CHANGE NUMBER: 128

**Reason for Change from Prior Estimate:**

Updated information was provided by CDSS.

**CASH BASIS**

(In Thousands)

**FY 2011-12**

<u>TF</u>	<u>CDSS GF</u>	<u>County Share</u>	<u>FFP Regular</u>	<u>FFP ARRA</u>	<u>Total FFP</u>
\$5,307,510	\$1,696,321	\$913,404	\$2,653,755	\$44,030	<b>\$2,697,785</b>

**FY 2012-13**

<u>TF</u>	<u>CDSS GF</u>	<u>County Share</u>	<u>FFP Regular</u>	<u>FFP ARRA</u>	<u>Total FFP</u>
\$5,050,071	\$1,641,273	\$883,762	\$2,525,036	\$0	<b>\$2,525,036</b>

**Funding:**

Title XIX 100% FFP (4260-101-0890)

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

BASE POLICY CHANGE NUMBER: 129  
 IMPLEMENTATION DATE: 7/1988  
 ANALYST: Humei Wang  
 FISCAL REFERENCE NUMBER: 76

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$2,477,512,000	\$2,485,702,000
- STATE FUNDS	\$1,321,763,000	\$1,324,429,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,477,512,000	\$2,485,702,000
STATE FUNDS	\$1,321,763,000	\$1,324,429,000
FEDERAL FUNDS	\$1,155,749,000	\$1,161,273,000

### DESCRIPTION

**Purpose:**

The policy change estimates Medi-Cal's expenditures for Medicare Part A and Part B premiums.

**Authority:**

California Code of Regulations, §50777 of Title 22  
 Social Security Act, section 1843.

**Background:**

The policy change estimates the costs for Part A and Part B premiums for Medi-Cal eligibles that are also eligible for Medicare coverage.

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. This policy change also includes adjustments due to reconciliations of state and federal data.
2. The Centers for Medicare and Medicaid set the following 2012 premiums: Medicare Part A increased by \$1.00 to \$451 and Medicare Part B decreased by \$15.50 to \$99.90.
3. The 2013 premiums are estimated to increase by \$1.00 to \$452 for Medicare Part A, the same growth rate as 2012. The Medicare Part B premium is estimated to increase by \$4.37 to \$104.27, a 4.38% increase. The 4.38% increase is the average annual increase in Medicare Part B premiums between 2006 and 2008.

FY 2011-12	<u>Part A</u>	<u>Part B</u>
Average Monthly Eligibles	168,347	1,147,535
Rate 07/2011-12/2011	\$450.00	\$115.40
Rate 01/2012-06/2012	\$451.00	\$99.90

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

BASE POLICY CHANGE NUMBER: 129

**FY 2012-13**

Average Monthly Eligibles	173,963	1,177,192
Rate 07/2012-12/2012	\$451.00	\$99.90
Rate 01/2013-06/2013	\$452.00	\$104.27

## Funding:

Title XIX GF/FFP (4260-101-0001/0890)

## MENTAL HEALTH SERVICES-CDMH

**BASE POLICY CHANGE NUMBER:** 130  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Betty Lai  
**FISCAL REFERENCE NUMBER:** 75

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$1,228,325,000</b>	<b>\$1,677,313,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$1,228,325,000</b>	<b>\$1,677,313,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$1,228,325,000</b>	<b>\$1,677,313,000</b>

### DESCRIPTION

**Purpose:**

This policy change estimates the Title XIX federal financial participation (FFP) to be provided to the California Department of Mental Health (CDMH) for the Medi-Cal cost of specialty mental health services.

**Authority:**

Specialty Mental Health Service Consolidation -1915(b) Waiver

**Background:**

Specialty mental health services are provided to Medi-Cal beneficiaries through a waiver program administered by CDMH. The Centers for Medicare and Medicaid Services (CMS) has approved the waiver for the term of July 1, 2011 through June 30, 2013.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's federal medical assistance percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2011-12 and FY 2012-13.

The match for FY 2011-12 is funded by county realignment and Mental Health Services Act (MHSA) funds, replacing the state's General Fund. The match for FY 2012-13 is entirely funded by county realignment funds.

Effective July 1, 2012, the CDMH administrative contracts and associated federal funds will be shifted to the Department's state operations, as well as the mental health program responsibilities.

**Reason for Change from Prior Estimate:**

Revised based on additional information provided by CDMH.

**MENTAL HEALTH SERVICES-CDMH**

BASE POLICY CHANGE NUMBER: 130

**Methodology:**

1. The estimates, on a cash basis, were provided by CDMH and the Department.
2. The Department reimburses CDMH through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and outpatient interagency agreement (IA) # 02-25271.

<i>(In Thousands)</i>	<b>Title XIX FFP (50/50)</b>	<b>Title XXI FFP (65/35)</b>	<b>FFP ARRA</b>	<b>Total</b>
<b>FY 2011-12</b>				
EPSDT	\$629,355		\$27,760	\$657,115
Outpatient	\$385,380		\$17,660	\$403,040
Inpatient-EDS	\$148,434		\$6,690	\$155,124
M-CHIP		\$13,046		\$13,046
<b>TOTAL</b>	<b>\$1,163,169</b>	<b>\$13,046</b>	<b>\$52,110</b>	<b>\$1,228,325</b>

	<b>Title XIX FFP (50/50)</b>	<b>Title XXI FFP (65/35)</b>	<b>FFP ARRA</b>	<b>Total</b>
<b>FY 2012-13</b>				
EPSDT	\$886,749	32,047	\$1,149	\$919,945
Outpatient	\$579,361		\$728	\$580,089
Inpatient-EDS	\$154,917	7,580	\$280	\$162,777
M-CHIP		\$14,502		\$14,502
<b>TOTAL</b>	<b>\$1,621,027</b>	<b>\$54,129</b>	<b>\$2,157</b>	<b>\$1,677,313</b>

	<b>Total Funds</b>	<b>County</b>	<b>FFP MCHIP</b>	<b>FFP Regular</b>	<b>FFP ARRA</b>	<b>TOTAL FFP</b>
<b>FY 2011-12</b>	\$2,424,608	\$1,183,237	\$13,046	\$1,176,215	\$52,110	<b>\$1,228,325</b>
<b>FY 2012-13</b>	\$3,435,742	\$1,704,300	\$54,129	\$1,675,156	\$2,157	<b>\$1,677,313</b>

**Funding:**

Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-113-0890)

## MEDICARE PAYMENTS - PART D PHASED-DOWN

**BASE POLICY CHANGE NUMBER:** 131  
**IMPLEMENTATION DATE:** 1/2006  
**ANALYST:** Jade Li  
**FISCAL REFERENCE NUMBER:** 1019

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$1,400,152,000	\$1,465,483,000
- STATE FUNDS	\$1,400,152,000	\$1,465,483,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,400,152,000	\$1,465,483,000
STATE FUNDS	\$1,400,152,000	\$1,465,483,000
FEDERAL FUNDS	\$0	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates Medi-Cal's Medicare Part D expenditures.

**Authority:**

The Medicare Prescription Drug, Improvement, And Modernization Act (MMA) of 2003

**Background:**

On January 1, 2006, Medicare's Part D benefit began. Part D provides a prescription drug benefit to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. Dual eligible beneficiaries 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 eligible beneficiaries. 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 2/3% each year until it reaches 75% (CY 2007 = 88 1/3%, CY 2008 = 86 2/3%, etc). The MMA of 2003 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 phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. FY 2011-12 payments will include payments for the May and June 2011 with ARRA, along with any additional retroactive adjustments. The GF savings generated from the higher FMAP is shown in the Medicare Payments – Part D Phased-down ARRA policy change.

Medi-Cal's Part D Per Member Per Month (PMPM) rate:

**MEDICARE PAYMENTS - PART D PHASED-DOWN**

BASE POLICY CHANGE NUMBER: 131

<u>Calendar Year</u>	<u>PMPM rate</u>
2009	\$99.82
2010	\$102.54
2011	\$100.77
2012	\$102.76
2013	\$103.92 (estimated)

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

<u>Fiscal Year</u>	<u>Total Payment</u>	<u>Ave. Monthly Beneficiaries</u>
FY 2008-09	\$1,213,987,168	1,060,669
FY 2009-10	\$864,850,294	1,085,366
FY 2010-11	\$1,049,777,643	1,113,792

**Reason for Change from Prior Estimate:**

Updated data on the 2013 estimated growth in the PMPM and monthly dual eligible Part D enrollment.

**Methodology:**

1. The growth increase in the Medicare Part D PMPM for calendar year 2011 was 0.28% and Medi-Cal's PMPM increased to \$100.77.
2. The growth increase in the Medicare Part D PMPM for calendar year 2012 is 4.10% and Medi-Cal's estimated PMPM is estimated to increase to \$102.76.
3. The 2013 growth increase is assumed to be 3.31%, the unadjusted 2012 estimated growth increase, and Medi-Cal's estimated PMPM is expected to increase to \$103.92.
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 2011 is received in June 2011 and payment is due in July 2011.
5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly dual eligible Part D enrollment data for July 2008–February 2012.
6. The Phased-down Contribution is funded 100% by State General Fund.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
<b>FY 2011-12</b>	12	1,054,450	\$116,679,371	<b>\$1,400,152,000</b>
<b>FY 2012-13</b>	12	1,183,939	\$122,123,601	<b>\$1,465,483,000</b>

**Funding:**

State Only General Fund (4260-101-0001)

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

**BASE POLICY CHANGE NUMBER:** 132  
**IMPLEMENTATION DATE:** 7/1990  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 23

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$1,115,755,000</b>	<b>\$1,089,699,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$1,115,755,000</b>	<b>\$1,089,699,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$1,115,755,000</b>	<b>\$1,089,699,000</b>

**DESCRIPTION****Purpose:**

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Home & Community Based Services (HCBS) program.

**Authority:**

Interagency agreement (IA)

**Background:**

CDDS, under a federal 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). Services include home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, home and vehicle modifications, prevocational services, skilled nursing, residential services, specialized therapeutic services, and transition/set-up expenses.

While the General Fund for this issue is in the CDDS budget on an accrual basis, the federal funds in the Department's budget are on a cash basis.

**Reason for Change from Prior Estimate:**

No material change.

**Methodology:**

1. The following estimates have been provided by CDDS:

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

BASE POLICY CHANGE NUMBER: 132

<b>CASH BASIS</b> (In Thousands)	<b>Total</b> <b>Funds</b>	<b>CDDS</b> <b>GF</b>	<b>DHCS</b> <b>FFP</b>	<b>IA #</b>
<b>FY 2011-12</b>	\$2,231,509	\$1,115,754	<b>\$1,115,755</b>	01-15834
<b>FY 2012-13</b>	\$2,179,397	\$1,089,698	<b>\$1,089,699</b>	01-15834

**Funding:**

Title XIX 100% FFP (4260-101-0890)

## DENTAL SERVICES

**BASE POLICY CHANGE NUMBER:** 134  
**IMPLEMENTATION DATE:** 7/1988  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 135

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$482,799,000	\$526,115,000
- STATE FUNDS	\$237,771,900	\$259,429,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$482,799,000	\$526,115,000
STATE FUNDS	\$237,771,900	\$259,429,900
FEDERAL FUNDS	\$245,027,100	\$266,685,100

### DESCRIPTION

**Purpose:**

The policy change estimates the cost of dental services provided by Delta Dental.

**Authority:**

Social Security Act, Title XIX

**Background:**

Delta Dental has an at-risk contract to provide dental services to most Medi-Cal beneficiaries at a prepaid capitated rate per eligible. These dental costs are for fee-for-service (FFS) Medi-Cal beneficiaries. Effective July 1, 2009, the dental costs included the impact of the reduction to dental services for adults. Dental costs for beneficiaries with dental managed care plans are shown in the Dental Managed Care policy change.

**Reason for Change from Prior Estimate:**

Revised based on additional actual data.

**Methodology:**

1. The capitation rates for August 1, 2010 – July 31, 2011 are \$6.70 for regular eligibles and \$7.06 for refugees.
2. The capitation rates for August 1, 2011 – June 30, 2012 are \$6.03 for regular eligibles and \$3.35 for refugees.
3. No rate adjustments have been included for FY 2012-13. The prior period rates have been used.
4. 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, 2010 resulted in an underwriting gain of \$38 million. According to contract distribution provisions the state received \$33.4 million and Delta Dental retained \$4.6 million in FY 2011-12.

## DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 134

5. 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.

FY 2011-12	Rate <sup>1</sup>	Average Monthly Eligibles	Total Funds
Regular 7/11	\$6.70	6,522,616	\$43,702,000
Regular 8/11 – 6/12	\$6.03	6,542,304	\$433,951,000
Refugee <sup>3</sup> 7/11	\$7.06	1,882	\$13,000
Refugee <sup>3</sup> 8/11 – 6/12	\$3.35	1,906	\$70,000
Other FFS	Non-Capitated		\$38,463,000
		Subtotal	\$516,199,000
Underwriting Gain <sup>2</sup>			(\$33,400,000)
<b>FY 2011-12 Dental Total</b>			<b>\$482,799,000</b>

FY 2012-13	Rate <sup>1</sup>	Average Monthly Eligibles	Total Funds
Regular 7/12 – 6/13	\$6.03	6,637,345	\$480,278,000
Refugee <sup>3</sup> 7/12 – 6/13	\$3.35	2,602	\$105,000
Other FFS	Non-Capitated		\$45,732,000
<b>FY 2012-13 Dental Total</b>			<b>\$526,115,000</b>

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

Title XXI 65/35 FFP (4260-113-0001/0890)

## DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

**BASE POLICY CHANGE NUMBER:** 135  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 77

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$262,857,000	\$205,349,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$262,857,000	\$205,349,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$262,857,000	\$205,349,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Developmental Centers (DCs) and State Operated Small Facilities (SOSFs).

**Authority:**

Interagency Agreement (IA)

**Background:**

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOSFs. There are five DCs and two 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.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2011-12 and FY 2012-13.

The General Fund (GF) is included in the CDDS budget on an accrual basis, the federal funds in the Department's budget are on a cash basis.

**Reason for Change from Prior Estimate:**

No material change.

**Methodology:**

1. The following estimates have been provided by CDDS.

**DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**

BASE POLICY CHANGE NUMBER: 135

<b>CASH BASIS</b> (In Thousands)	<b>Total Funds</b>	<b>CDDS GF</b>	<b>FFP Regular</b>	<b>FFP ARRA</b>	<b>Total FFP</b>	<b>IA #</b>
<b>FY 2011-12</b>	\$504,394	\$241,537	\$252,075	\$10,782	<b>\$262,857</b>	01-15834
<b>FY 2012-13</b>	\$410,548	\$205,199	\$205,274	\$75	<b>\$205,349</b>	01-15834

**Funding:** Title XIX 100% FFP (4260-101-0890)

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

**BASE POLICY CHANGE NUMBER:** 137  
**IMPLEMENTATION DATE:** 7/1991  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 26

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$148,553,000</b>	<b>\$138,469,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$148,553,000</b>	<b>\$138,469,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$148,553,000</b>	<b>\$138,469,000</b>

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

**Authority:**

Interagency Agreement (IA)

**Background:**

Authorized by the Lanterman Act, the Department entered into an IA with CDDS to reimburse the Title XIX federal financial participation (FFP) for targeted case management services for Medi-Cal eligible clients. There are 21 CDDS Regional Centers statewide that provide these services. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible.

The General Fund is in the CDDS budget on an accrual basis, the federal funds in the Department's budget are on a cash basis.

**Reason for Change from Prior Estimate:**

No material change.

**Methodology:**

1. The following estimates have been provided by CDDS:

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

BASE POLICY CHANGE NUMBER: 137

<b>CASH BASIS</b> (In Thousands)	<b>Total</b> <b>Funds</b>	<b>CDDS GF</b>	<b>DHCS</b> <b>FFP</b>	<b>IA #</b>
<b>FY 2011-12</b>	\$297,106	\$148,553	<b>\$148,553</b>	03-75284
<b>FY 2012-13</b>	\$276,939	\$138,470	<b>\$138,469</b>	03-75284

**Funding:**

Title XIX 100% FFP (4260-101-0890)

**DRUG MEDI-CAL-CDADP**

**BASE POLICY CHANGE NUMBER:** 138  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 84

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$58,670,000	\$154,869,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$58,670,000	\$154,869,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$58,670,000	\$154,869,000

**DESCRIPTION****Purpose:**

This policy change estimates the Title XIX federal financial participation (FFP) to be provided to the California Department of Alcohol and Drug Programs (CDADP) for the administration of Drug/Medi-Cal services to Medi-Cal beneficiaries.

**Authority:**

Interagency Agreement

**Background:**

The Drug/Medi-Cal program provides substance abuse treatment services to Medi-Cal beneficiaries in an outpatient setting.

Drug/Medi-Cal services are reimbursed on a fee-for-service (FFS) basis. These community treatment services are carved out from the regular Medi-Cal program and are administered by the CDADP.

**Reason for Change from Prior Estimate:**

Revised based on additional information from CDADP.

**Methodology:**

1. Services paid by the CDADP between October 1, 2008 and June 30, 2011, billed to the Department of Health Care Services in FY 2011-12 are eligible to receive the increased FMAP.
2. Assume the Local Revenue Fund (LRF) match is provided by CDADP.
3. The estimates, on a cash basis, were provided by CDADP.
4. CDADP General Fund (GF) dollars have been changed to LRF, consistent with the removal of GF from CDADP's budget and the shift of programmatic responsibility to the county level.
5. Effective July 1, 2012, the Drug/Medi-Cal programs and associated funding will be shifted to the Department.

**DRUG MEDI-CAL-CDADP**  
**BASE POLICY CHANGE NUMBER: 138**

(In Thousands)	<u>Total Funds</u>	<u>LRF</u>	<u>Regular FFP</u>	<u>ARRA FFP</u>	<u>Total FFP</u>	<u>IA #</u>
FY 2011-12	\$127,464	\$68,794	\$57,690	\$980	<b>\$58,670</b>	04-35640
FY 2012-13	\$329,592	\$174,723	\$154,869	\$0	<b>\$154,869</b>	04-35640

**Funding:**

Title XIX 100% FFP (4260-101-0890)

## MEDI-CAL TCM PROGRAM (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 139  
**IMPLEMENTATION DATE:** 6/1995  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 27

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$59,617,000</b>	<b>\$57,621,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$59,617,000</b>	<b>\$57,621,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$59,617,000</b>	<b>\$57,621,000</b>

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

**Authority:**

SB 910 (Chapter 1179, Statutes of 1991), Welfare and Institutions Code Section 14132.44

**Background:**

The TCM program provides funding to counties and chartered cities and LGAs for assisting Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, local governmental agencies submit invoices to the Department to claim federal financial participation (FFP) for these case services. The following target groups are currently served in the TCM program: children under 21, medically fragile individuals 18 and over, individuals at risk of institutionalization, individuals at risk of negative health or psycho-social outcomes, and individuals with communicative diseases.

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be mandatorily enrolled into a managed care plan in Two-Plan and Geographic Managed Care model counties. The Centers for Medicare and Medicaid Services (CMS) has required coordination protocols between TCM providers and managed care health plans to avoid duplicate services. This coordination should not affect the amount of TCM Services claimed.

**Reason for Change from Prior Estimate:**

American Recovery and Reinvestment Act of 2009 (ARRA) claims projection lowered in FY 2011-12 and FY 2012-13.

**Methodology:**

- Under the ARRA, California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid

**MEDI-CAL TCM PROGRAM (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 139**

Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as Medi-Cal TCM program payments when Medi-Cal draws the federal funds in a subsequent fiscal year.
3. The Medi-Cal TCM program has an eight-quarter delay in paying the ARRA claims. Due to this delay ARRA will be claimed in FY 2011-12 and 2012-13 for prior-year claims.
4. Analysis of actual cash flows for the fiscal period of July 1, 2011 through January 31, 2012 was prepared and included a trending of estimated future cash flows for each fiscal period.

(In Thousands)	<u>Regular FFP</u>	<u>ARRA</u>	<u>Total FFP</u>
<b>FY 2011-12</b>	\$ 56,067	\$ 3,550	<b>\$ 59,617</b>
<b>FY 2012-13</b>	\$ 56,067	\$ 1,554	<b>\$ 57,621</b>

**Funding:**

Title XIX FFP (4260-101-0890)

## EPSDT SCREENS

**BASE POLICY CHANGE NUMBER:** 140  
**IMPLEMENTATION DATE:** 7/2001  
**ANALYST:** Yumie Park  
**FISCAL REFERENCE NUMBER:** 136

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$52,096,000	\$53,242,000
- STATE FUNDS	\$26,048,000	\$26,621,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$52,096,000	\$53,242,000
STATE FUNDS	\$26,048,000	\$26,621,000
FEDERAL FUNDS	\$26,048,000	\$26,621,000

### DESCRIPTION

**Purpose:**

This policy change estimates the screening costs for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

**Authority:**

Title 22, California Code of Regulations, Section 51340 (a)

**Background:**

The Child Health and Disability Prevention (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.

**Reason for Change from Prior Estimate:**

Increase in the number of screens for FY 2011-12 and FY 2012-13.

**Methodology:**

Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2011-12 and FY 2012-13, based on a historical trend dating back to July 2006.

**FY 2011-12**

Screens 1,007,052 x \$51.73 (weighted average) = **\$52,096,000** (rounded)

**FY 2012-13**

Screens 944,765 x \$56.35 (weighted average) = **\$53,242,000** (rounded)

**Funding:**

Title XIX (4260-101-0001/0890)

## WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 141  
**IMPLEMENTATION DATE:** 4/2000  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 32

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$35,510,000	\$38,751,000
- STATE FUNDS	\$17,755,000	\$19,375,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$35,510,000	\$38,751,000
STATE FUNDS	\$17,755,000	\$19,375,500
FEDERAL FUNDS	\$17,755,000	\$19,375,500

### DESCRIPTION

**Purpose:**

This policy change estimates the costs associated with adding personal care services (PCS) to the Nursing Facility (NF) Waivers.

**Authority:**

AB 668 (Chapter 896, Statutes of 1998)

**Background:**

AB 668 authorized additional hours on behalf of eligible PCS Program recipients if they needed more than the monthly hours allowed under the In-Home Supportive Services Program (IHSS) and qualified for the Medi-Cal Skilled Nursing Facility Level of Care Home and Community Based Services (HCBS) Waiver program. NF Level A/B, NF Subacute (S/A), and In-Home Medical Care Waivers were merged into two waivers called the Nursing Facility/Acute Hospital (NF/AH) Waiver and the In-Home Operations (IHO) Waiver. These waivers provide HCBS to Medi-Cal eligible waiver participants using specific level of care (LOC) criteria. Waiver Personal Care Services (WPCS) under these two waivers include services that differ from those in the State Plan which allow beneficiaries to remain at home. Although there is no longer a requirement that waiver consumers receive the maximum of 283 hours of IHSS prior to receiving WPCS, waiver consumers must first utilize authorized State Plan IHSS hours prior to accessing this waiver service. These services are provided by the counties' IHSS program providers and paid via an interagency agreement with the Department or will be provided by home health agencies and other qualified HCBS waiver provider types paid via the Medi-Cal fiscal intermediary.

**Reason for Change from Prior Estimate:**

The costs for FY 2011-12 were reduced as a result of fewer than expected enrollees. The costs for FY 2012-13 were reduced, based on actual data, due to an anticipated reduction of WPCS hours utilized by WPCS beneficiaries.

**Methodology:**

1. Assume the number of current NF A/B Level of Care (LOC) Waiver beneficiaries using Waiver PCS is estimated to increase by an average of 15 per month in FY 2011-12 and FY 2012-13.

**WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 141**

2. Assume the number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by two per month in FY 2011-12 and one per month in FY 2012-13.
3. The Department expects to enroll 314 beneficiaries during FY 2011-12 and 360 beneficiaries during FY 2012-13 into the California Community Transitions (CCT) Demonstration Project. Based on actual data, 25% of the beneficiaries are expected to use Waiver PCS.
4. The average cost/hour is \$10.66 for FY 2011-12 and FY 2012-13.

**CASH BASIS****FY 2011-12 Costs: \$35,510,000****FY 2012-13 Costs: \$38,751,000****Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

## LAWSUITS/CLAIMS

**BASE POLICY CHANGE NUMBER:** 144  
**IMPLEMENTATION DATE:** 7/1989  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 93

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$11,354,000	\$1,865,000
- STATE FUNDS	\$5,677,000	\$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,354,000	\$1,865,000
STATE FUNDS	\$5,677,000	\$932,500
FEDERAL FUNDS	\$5,677,000	\$932,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Not applicable

**Background:**

State Legislature appropriates State dollars to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all lawsuit settlements approved by the Legislature and the Governor.

**Reason for Change from Prior Estimate:**

Additional lawsuit settlements.

**LAWSUITS/CLAIMS**

BASE POLICY CHANGE NUMBER: 144

**Methodology:**

	<b>Committed 2011-12</b>	<b>Balance 2011-12</b>	<b>Budgeted 2011-12</b>	<b>Budgeted 2012-13</b>
Attorney Fees <\$5,000	\$3,000	\$47,000	\$50,000 *	\$50,000 *
Provider Settlements <\$75,000	\$482,000	\$1,118,000	\$1,600,000 *	\$1,600,000 *
Beneficiary Settlements <\$ 2,000	\$0	\$15,000	\$15,000 *	\$15,000 *
Small Claims Court	\$5,000	\$195,000	\$200,000 *	\$200,000 *
Other Attorney Fees	\$2,289,000	\$0	\$2,289,000	\$0
Other Provider Settlements	\$7,200,000	\$0	\$7,200,000	\$0
Other Beneficiary Settlements	\$0	\$0	\$0	\$0
<b>TOTALS</b>	<b>\$9,979,000</b>	<b>\$1,375,000</b>	<b>\$11,354,000 *</b>	<b>\$1,865,000 *</b>

\* Represents potential totals.

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 149  
**IMPLEMENTATION DATE:** 1/1993  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 91

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$2,414,000	\$1,471,000
- STATE FUNDS	\$1,207,000	\$735,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,414,000	\$1,471,000
STATE FUNDS	\$1,207,000	\$735,500
FEDERAL FUNDS	\$1,207,000	\$735,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

**Authority:**

Welfare and Institutions Code, section 14124.91; Social Security Act, Title 19, section 1916; and California Code of Regulations, section 50788.

**Background:**

The Department pays the premium cost of private health insurance for high-risk beneficiaries under the HIPP program when payment of such premiums is cost effective. Premium costs are budgeted separately from other Medi-Cal benefits since premiums are paid outside of the regular Medi-Cal claims payment procedures.

**Reason for Change from Prior Estimate:**

The HIPP enrollment is declining due to mandatory enrollment of seniors and persons with disabilities (SPD) into managed care.

**Methodology:**

1. The average monthly premium cost is estimated to be \$505.44 in FY 2011-12 and \$537.65 in FY 2012-13.
2. The average monthly HIPP enrollment is estimated to be 398 in FY 2011-12 and 228 in FY 2012-13.

**HIPP PREMIUM PAYOUTS (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 149**

3. Costs for FY 2011-12 and FY 2012-13 are estimated to be:

**FY 2011-12:**  $\$505.44 \times 398 \times 12 \text{ Months} = \$2,414,000 \text{ TF } (\$1,207,000 \text{ GF})^*$

**FY 2012-13:**  $\$537.65 \times 228 \times 12 \text{ Months} = \$1,471,000 \text{ TF } (\$735,500 \text{ GF})^*$

**Funding:**

Title XIX 50/50 FFP (4260-101-0001/0890)

## CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 150  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1083

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$1,503,000	\$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	\$1,503,000	\$1,028,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,503,000	\$1,028,000

### DESCRIPTION

**Purpose:**

The policy change estimates the federal match provided to the California Department of Public Health (CDPH) for benefit costs associated with the Childhood Lead Poisoning Prevention (CLPP) Program.

**Authority:**

Interagency agreement (IA)

**Background:**

The 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. The federal match is provided to CDPH through interagency agreement #07-65689.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

- The estimates are provided by CDPH on a cash basis.

	<u>FY 2011-12</u>	<u>DHCS FFP</u>	<u>CDPH CLPP Fee Funds</u>
Benefits Costs	\$1,503,000	\$1,503,000	\$1,503,000

	<u>FY 2012-13</u>	<u>DHCS FFP</u>	<u>CDPH CLPP Fee Funds</u>
Benefits Costs	\$1,028,000	\$1,028,000	\$1,028,000

**Funding:**

Title XIX FFP (4260-101-0890)

## BASE RECOVERIES

**BASE POLICY CHANGE NUMBER:** 164  
**IMPLEMENTATION DATE:** 7/1987  
**ANALYST:** Cavan Donovan  
**FISCAL REFERENCE NUMBER:** 127

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	-\$265,809,000	-\$266,256,000
- STATE FUNDS	-\$159,087,000	-\$159,354,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$265,809,000	-\$266,256,000
STATE FUNDS	-\$159,087,000	-\$159,354,000
FEDERAL FUNDS	-\$106,722,000	-\$106,902,000

### DESCRIPTION

**Purpose:**

This policy change estimates the collection from estates, lawsuit settlements, providers, and other insurance to offset the cost of services provided by Medi-Cal.

**Authority:**

California Welfare and Institutions Code, sections 14124.70 – 14124.79, 14009, and 14007.9.  
California Code of Regulations, Title 22, sections 50781-50791.

**Background:**

Recoveries are credited to the Health Care Deposit Fund and 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.

**Reason for Change from Prior Estimate:**

Litigation settlements previously accounted for in General Collections has been moved to Litigation Settlements policy change.

**Methodology:**

1. Recoveries are estimated using the trend in the monthly recoveries for July 2008 - January 2012.
2. The General Fund ratio for collections is estimated to be 59.85% in FY 2011-12 and in FY 2012-13.

**BASE RECOVERIES**

BASE POLICY CHANGE NUMBER: 164

<b>Estimated Base Recoveries:</b>	<b>FY 2011-12</b>	<b>FY 2012-13</b>
Personal Injury Collections	\$43,232,000	\$43,452,000
Workers' Comp. Contract	\$2,700,000	\$2,800,000
H.I. Contingency Contract	\$73,000,000	\$80,000,000
General Collections	\$146,877,000	\$140,004,000
<b>TOTAL</b>	<b>\$265,809,000</b>	<b>\$266,256,000</b>

**Funding:**

Title XIX GF/FFP: (4260-101-0001/0890)