FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	1/1997
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$582,522,000	$600,407,000
- STATE FUNDS	$141,723,600	$146,075,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$582,522,000	$600,407,000
STATE FUNDS	$141,723,600	$146,075,200
FEDERAL FUNDS	$440,798,400	$454,331,800

DESCRIPTION

Purpose:
This policy change estimates the costs of family planning services provided by the Family Planning, Access, Care and Treatment (PACT) program.

Authority:
Welfare and Institutions Code, section 14132(aa)

Background:
Effective January 1, 1997, family planning services were expanded under the Family PACT program to provide contraceptive services to more persons in need of such services who have incomes under 200% of Federal Poverty Level. A Section 1115 demonstration project waiver was approved by Centers for Medicare & Medicaid Services (CMS) effective December 1, 1999.

A State Plan Amendment (SPA) was approved on March 24, 2011, in accordance with the Affordable Care Act, to transition the current Family PACT Waiver into the State Plan. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund receive a 90% federal financial participation (FFP), and family planning-related services receive reimbursement at Title XIX 50/50 FFP.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebate Program policy change.

Reason for Change from Prior Estimate:
There is no material change.

Methodology:
1. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.

2. The treatment of STIs and other family planning companion services are eligible for Title XIX 50/50 FFP.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1

3. The treatment of other medical conditions; including inpatient care for complications from family planning services are not eligible for FFP.

4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

	FY 2011-12		FY 2012-13	
Service Category	**TF**	**GF**	**TF**	**GF**
Physicians	$80,587,000	$19,606,000	$86,468,000	$21,037,000
Other Medical	$345,723,000	$84,112,000	$348,207,000	$84,716,000
County Outpatient	$3,322,000	$808,000	$3,595,000	$875,000
Community Outpatient	$4,288,000	$1,043,000	$4,502,000	$1,095,000
Pharmacy	$148,602,000	$36,154,000	$157,635,000	$38,351,000
Total	**$582,522,000**	**$141,723,000**	**$600,407,000**	**$146,074,000**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
GF (4260-101-0001)
Title XIX 90/10 FFP (4260-101-0001/0890)

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2
IMPLEMENTATION DATE: 1/2002
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 3

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$125,539,000	$138,724,000
- STATE FUNDS	$54,469,300	$59,847,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$125,539,000	$138,724,000
STATE FUNDS	$54,469,300	$59,847,150
FEDERAL FUNDS	$71,069,700	$78,876,850

DESCRIPTION

Purpose:
This policy change estimates the cost of the Breast and Cervical Cancer Treatment Program (BCCTP).

Authority:
AB 430 (Chapter 171, Statutes of 2001)

Background:
AB 430 authorized the BCCTP effective January 1, 2002, for women under 200% of the federal poverty level (FPL). Enhanced Title XIX Medicaid funds (35% GF/65% FFP) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

A State-Only program covers women aged 65 or older regardless of immigration status, individuals who are underinsured, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 24 months for cervical cancer. Estimated State-Only costs include undocumented persons' non-emergency services during cancer treatment.

Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Reason for Change from Prior Estimate:
Revised due to additional caseload projections and expenditures.

Methodology:
1. There were 10,191 fee-for-service (FFS) and 2,570 managed care eligibles as of January 2012 (total of 12,761). 2,452 of the FFS eligibles were eligible for State-Only services.

2. 682 of the FFS eligibles were in Accelerated Enrollment as of January 2012.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2

3. Assume the State will pay Medicare and other health coverage premiums for an average of 207 beneficiaries monthly in FY 2011-12 and FY 2012-13. Assume an average monthly premium cost per beneficiary of $250.10.

   FY 2011-12: 207 x $250.10 x 12 months = $620,000* TF ($620,000 GF) *Rounded
   FY 2012-13: 207 x $250.10 x 12 months = $620,000* TF ($620,000 GF) *Rounded

4. Costs are estimated as follows:

(Rounded)	FY 2011-12		FY 2012-13	
	TF	GF	TF	GF
Full Scope Costs	$109,338,000	$38,268,000	$121,349,000	$42,472,000
State-Only Costs				
Services	$15,581,000	$15,581,000	$16,755,000	$16,755,000
Premiums	$620,000	$620,000	$620,000	$620,000
Total	**$125,539,000**	**$54,469,000**	**$138,724,000**	**$59,847,000**

5. Federal reimbursement for a portion of State-Only BCCTP costs based on the certification of public expenditures is budgeted in the policy change MH/UCD – BCCTP.

Funding:

FY 2011-12:		GF	FF	TF
General Fund	4260-101-001	$16,201,000	$ 0	**$16,201,000**
Title XIX 35/65 FFP	4260-101-0001/0890	$38,268,000	$71,070,000	**$109,338,000**

FY 2012-13:		GF	FF	TF
General Fund	4260-101-001	$17,375,000	$ 0	**$17,375,000**
Title XIX 35/65 FFP	4260-101-0001/0890	$42,472,000	$78,877,000	**$121,349,000**

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 3
IMPLEMENTATION DATE: 7/2008
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 8

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$11,671,000	$10,615,000
- STATE FUNDS	$4,084,850	$4,929,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,671,000	$10,615,000
STATE FUNDS	$4,084,850	$4,929,950
FEDERAL FUNDS	$7,586,150	$5,685,050

DESCRIPTION

Purpose:
This policy change estimates the cost of providing pre-enrollment (PE) into the Healthy Families Program (HFP) for children who receive a Children's Health and Disability Program (CHDP) screening.

Authority:
Welfare & Institutions Code, section 14011.7
AB 442 (Chapter 1161, Statutes of 2002)

Background:
The CHDP Gateway program was implemented July 1, 2003. Children who receive a CHDP screen receive PE into Medi-Cal or the HFP. PE provides a minimum of 2 months of full-scope coverage, during which the family may apply for ongoing Medi-Cal or HFP coverage. The state-funded CHDP program continues to provide screens to children eligible for limited-scope Medi-Cal.

Effective October 1, 2012, the HFP will cease to enroll new applicants and will be phased-out over a nine-month period. Children enrolled in the HFP will be transitioned to the Medi-Cal program, and children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal.

Reason for Change from Prior Estimate:
Updated FY 2011-12 data on eligibles for aid code 8X, and the HFP transition to Medi-Cal proposal.

Methodology:
1. Based on June 2009 through February 2012 eligible data there will be 527,698 children (57,010 HFP, 432,052 Medi-Cal and 38,636 CHDP State-Only) in FY 2011-12 and 457,990 children (12,295 HFP, 38,007 Shift of HFP to Medi-Cal, 376,244 Medi-Cal and 31,444 CHDP State-Only) in FY 2012-13 who will be screened through the Gateway.

2. Based on November 2010 through August 2011 cost data and August 2010 through May 2011 eligible data, the per member per month (PMPM) cost for HFP PE is $204.72.

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 3

3. Based on January 2011 through December 2011 cost data and October 2010 through September 2011 eligible data, the PMPM cost for Medi-Cal PE is $213.06.

4. The funding for the Childhood Lead Poisoning Prevention (CLPP), previously included in this policy change, is now budgeted in the Childhood Lead Poisoning Prevention (CLPP) policy change.

5. The estimated FY 2011-12 and FY 2012-13 HFP and Medi-Cal PE costs are as follows:

FY 2011-12:	**Avg. Mo. Eligibles**	**TF**	**GF**
Medi-Cal PE	36,004	$ 92,054,000	$ 46,027,000
HFP PE	**4,751**	**$ 11,671,000**	**$ 4,085,000**
Total		$ 103,725,000	$ 50,112,000

FY 2012-13:	**Avg. Mo. Eligibles**	**TF**	**GF**
HFP PE*	**4,098**	**$ 2,517,000**	**$ 881,000**
Shift HFP to Medi-Cal PE	**4,223**	**$ 8,098,000**	**$ 4,049,000**
		$ 10,615,000	**$ 4,930,000**
Medi-Cal PE	31,961	$ 80,163,000	$ 40,081,500
Total		$ 90,778,000	$ 45,011,500

**Due to the Shift of HFP into Medi-Cal, HFP PE is based on three months of impact in FY 2012-13. The other nine months is captured in the Shift HFP to Medi-Cal PE.*

Funding:
Title XXI 35/65 FFP (4260-113-0001/0890)
Title XIX 50/50 FFP (4260-101-0001/0890)

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 11/1998
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 5

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$19,221,000	$4,828,000
- STATE FUNDS	$6,727,350	$1,689,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,221,000	$4,828,000
STATE FUNDS	$6,727,350	$1,689,800
FEDERAL FUNDS	$12,493,650	$3,138,200

DESCRIPTION

Purpose:
This policy change estimates the expenditures for children placed in the Bridge to Healthy Families Program (HFP).

Authority:
AB 2780 (Chapter 310, Statutes of 1998)

Background:
In order to allow time for families to apply for the HFP for their children, AB 2780 provides one month additional Medi-Cal eligibility as a bridge for children who become ineligible for Medi-Cal without a share-of-cost or are eligible for Medi-Cal with a share-of-cost and have income less than 250% of poverty (aid code 7X). The costs for this program are not included in the Medi-Cal base estimate. They are added through this policy change.

Effective October 1, 2012, the HFP will cease to enroll new applicants and will be phased-out over a nine-month period, which will eliminate the need for the bridge from Medi-Cal to the HFP.

Reason for Change from Prior Estimate:
Change due to additional caseload and cost data. Also, the Shift of HFP to Medi-Cal proposal will eliminate this program.

Methodology:
1. Based on current Medi-Cal data, 132,431 children in FY 2011-12 and 34,288 children in FY 2012-13 are expected to receive one-month bridge (aid code 7 X). The average monthly number of beneficiaries will be 11,036 in FY 2011-12 and 11,429 in FY 2012-13.

2. The FFS eligible months for aid code 7X are estimated to be 29,696 in FY 2011-12 and 7,372 in FY 2012-13. The managed care eligible-months for aid code 7X are estimated to be 102,736 in FY 2011-12 and 26,916 in FY 2012-13.

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 4

3. Based on cost data from November 2011 through August 2011 and eligible data from August 2010 through May 2011, the FFS PMPM cost for aid code 7X is $45.37. The total FFS expenditures for aid code 7X will be $1,347,000 in FY 2011-12 and $334,500 in FY 2012-13.

   FY 2011-12: $45.37 PMPM x 29,696 = $1,347,000
   FY 2012-13: $45.37 PMPM x 7,372 = $334,500

4. Based on cost data from November 2011 through August 2011 and eligible data from August 2010 through May 2011, the total average monthly managed care carve-out cost for aid code 7X is $20.14. The total managed care carve-out expenditures for aid code 7X will be $2,069,000 in FY 2011-12 and $542,000 in FY 2012-13.

   FY 2011-12: $20.14 Carve-Out x 102,736 = $2,069,000
   FY 2012-13: $20.14 Carve-Out x 26,916 = $542,000

5. The managed care capitation cost for aid code 7X will be $15,804,000 in FY 2011-12 and $3,951,000 in FY 2012-13.

6. The total managed care cost for aid code 7X will be $17,874,000 in FY 2011-12 and $4,493,000 in FY 2012-13.

   FY 2011-12: $2,069,000 Carve-Out + $15,804,000 Capitation = $17,874,000
   FY 2012-13: $542,000 Carve-Out + $3,951,000 Capitation = $4,493,000

7. Total expenditures for aid code 7X are expected to be $19,221,000 TF in FY 2011-12 and $4,828,000 TF in FY 2012-13.

   FY 2011-12: $1,347,000 + $17,874,000 = **$19,221,000 TF**
   FY 2012-13: $334,500 + $4,493,000 = **$4,827,500 TF**

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

CRAIG V. BONTA DISALLOWANCE

REGULAR POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 3/2012
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1623

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$12,337,000	$0
- STATE FUNDS	$12,337,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,337,000	$0
STATE FUNDS	$12,337,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the disallowance against claims for federal financial participation (FFP) for persons, who were determined to be ineligible for Medicaid during the period of April 1, 2003 through September 30, 2004.

Authority:
Not Applicable

Background:
As a result of *Craig v. Bontá,* counties were instructed that Medi-Cal beneficiaries losing Supplemental Security Income and State Supplemental Payment (SSI/SSP) based Medi-Cal on or after June 30, 2002, cannot have their Medi-Cal eligibility automatically discontinued. These cases must first be reviewed and evaluated for eligibility in other Medi-Cal programs using the three-step SB 87 redetermination process.

The Centers for Medicare and Medicaid Services (CMS) has determined there is a disallowance of federal funding for failure to make prompt Medicaid eligibility determinations after beneficiaries were found to be ineligible for SSI based Medi-Cal. The Department will provide repayment of FFP to CMS.

Reason for Change from Prior Estimate:
There is no change.

Methodology:

	FY 2011-12
Total General Fund Cost	**$12,337,000**

Funding:
100% State GF (4260-101-0001)

LANTERMAN DEVELOPMENTAL CENTER CLOSURE

REGULAR POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 3/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1560

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$607,000	$7,372,000
- STATE FUNDS	$303,500	$3,686,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$607,000	$7,372,000
STATE FUNDS	$303,500	$3,686,000
FEDERAL FUNDS	$303,500	$3,686,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the closure of the Lanterman Development Center.

Authority:
AB 97 (Chapter 3, Statutes of 2011)

Background:
On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families and the regional centers to transition residents to community living arrangements beginning in FY 2011-12. Residents moving into the community will be enrolled in a Medi-Cal managed care health plan or receive services through the Medi-Cal fee-for-service system.

Reason for Change from Prior Estimate:
Updated implementation date.

Methodology:
1. Under CDDS' Plan for Closure of Lanterman Developmental Center, the individual planning process will be the basis for ensuring that each resident's needs and choices are identified and appropriately addressed in the community. Therefore, the costs of the services to be provided through the Medi-Cal program once the residents transition to the community are unknown at this time.

2. Placeholder costs of $607,000 ($303,500 GF) for FY 2011-12 and $7,372,000 ($3,686,000 GF) for FY 2012-13 are included in the May 2012 Medi-Cal Estimate.

3. Assume 70 residents will transition from Lanterman Developmental Center into the community in 2011-12 and 110 residents will transition in 2012-13.

Funding:
Title XIX 50/50 FFP (4260-101-0890)

REFUGEES

REGULAR POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/1980
ANALYST: Luna Woo
FISCAL REFERENCE NUMBER: 14

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$3,573,000	$5,674,000
- STATE FUNDS	$3,573,000	$5,674,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,573,000	$5,674,000
STATE FUNDS	$3,573,000	$5,674,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the refugees' medical expenditures to be reimbursed by the California Department of Public Health (CDPH).

Authority:
Interagency Agreement

Background:
Full federal funding is available through the Refugee Resettlement Program (RRP) for medical services to refugees receiving Refugee Cash Assistance (Aid Codes 01, 08, and 0A) and for Refugee Medical Assistance refugees (Aid Code 02) during their first 8 months in the United States.

The RRP federal grant is administered by CDPH, which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement allows only one grant award for refugee health services in the state. The Department of Health Care Services invoices the CDPH for the reimbursement of refugee expenditures, which are originally funded with General Fund.

Reason for Change from Prior Estimate:
Lower refugee eligibles than previously estimated.

Methodology:
Total refugee expenditures to be reimbursed by CDPH are estimated to be $3,573,000 in FY 2011-12 and $5,674,000 in FY 2012-13.

Funding:
Reimbursements (4260-610-0995)

MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 4/2012
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1569

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$7,663,000	$6,628,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,663,000	$6,628,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$7,663,000	$6,628,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR) for the cost of inpatient services for inmates who are deemed eligible for Medi-Cal.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)

Background:
AB 1628 authorizes the Department and the CDCR to claim federal reimbursement for inpatient hospital services for adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties.

CDCR will utilize the Medi-Cal applications currently used by counties, and the Department will review these applications to make an eligibility determination according to current standard eligibility rules. Healthcare costs of state inmates are currently paid by the State General Fund. Federal Medicaid regulations and federal guidance provided to states allow for coverage of inpatient services to eligible inmates when provided in off-site facilities. The Department currently has an interagency agreement with CDCR in order to claim Title XIX FFP.

Reason for Change from Prior Estimate:
The estimates for monthly Medi-Cal and LIHP applications were updated for additional actual caseload data and Medical Parolees.

Methodology:
1. Implementation began April 1, 2011 and reimbursements will begin April 2012.

MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

REGULAR POLICY CHANGE NUMBER: 8

2. Claims may be filed retroactively to January 1, 2011. It is assumed that the cost of retroactive claims from January 1, 2011 through March 31, 2011, will be insignificant and therefore will not be budgeted for in this policy change. Claims in the amount of $2,703,000 for the period of April 1, 2011 to September 30, 2011 will be included in the FY 2011-12 costs.

3. Applications for Medi-Cal will be processed by the Department if the applicant received off-site inpatient related services. Costs for inmates eligible for LIHP are budgeted in the LIHP Inpatient Hosp. Costs for CDCR Inmates policy change.

4. It is assumed the Department will process 500 applications per month for inmates with verified citizenship.

5. Of the estimated 500 monthly applications it is assumed 25% in FY 2011-12 and 20% in FY 2012-13 are for Medi-Cal. Of the Medi-Cal applications, it is assumed 75% are age 65 or older, 15% are disabled, 5% are for pregnancy events, and 5% are under 21 years of age.

Monthly Applications	**FY 2011-12**							**FY 2012-13**						
Aged	500	x	25%	x	75%	=	**94**	500	x	20%	x	75%	=	**75**
Disabled	500	x	25%	x	15%	=	**19**	500	x	20%	x	15%	=	**15**
Pregnancy Event	500	x	25%	x	5%	=	**6**	500	x	20%	x	5%	=	**5**
Under 21	500	x	25%	x	5%	=	**6**	500	x	20%	x	5%	=	**5**

6. Assume 96 percent of the Medi-Cal monthly applicants will become eligible.

7. Based on birth events data 30% of the annual birth events will be for cesarean deliveries and 70% will be for vaginal deliveries.

8. Based on fee-for-service (FFS) cost data the average per member per month (PMPM) cost for an inpatient admission is $9,506 for aged, $11,751 for disabled, and $9,401 for under 21.

9. Based on FFS delivery cost data the average PMPM cost per event is $5,931 for cesarean delivery and $3,759 for a vaginal delivery.

10. In FY 2011-12 and FY 2012-13, it is assumed the Department will process 25 applications monthly for Medical Parolees with verified citizenship. It is assumed these eligibles will receive long term care (LTC) services.

11. Based on FFS cost data the average PMPM cost for a LTC eligible is $7,576.

300 LTC eligible months x $7,576 = $2,273,000 ($1,136,500 FF)

MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

REGULAR POLICY CHANGE NUMBER: 8

12. The total cost will be $15,326,000 ($7,663,000 FF) in FY 2011-12 and $13,256,000 ($6,628,000 FF) in FY 2012-13 and annually.

	FY 2011-12		FY 2012-13	
(Rounded)	TF	FF	TF	FF
Apr- Sep Retro	$2,703,000	$1,351,500	-	-
Medical Parole	$2,273,000	$1,136,500	$2,273,000	$1,136,500
Aged	$7,700,000	$3,850,000	$8,213,000	$4,106,500
Disabled	$1,904,000	$952,000	$1,974,000	$987,000
Under 21	$508,000	$254,000	$542,000	$271,000
Delivery	$238,000	$119,000	$254,000	$127,000
Total	$15,326,000	**$7,663,000**	$13,256,000	**$6,628,000**

Funding:
Title XIX FFP (4260-101-0890)

LOMELI V. SHEWRY

REGULAR POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 12/2011
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1583

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$294,000	$504,000
- STATE FUNDS	$147,000	$252,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	29.43 %	15.39 %
APPLIED TO BASE		
TOTAL FUNDS	$207,500	$426,400
STATE FUNDS	$103,740	$213,220
FEDERAL FUNDS	$103,740	$213,220

DESCRIPTION

Purpose:
This policy change estimates the cost of reimbursements made to Supplemental Security Income (SSI) beneficiaries for out-of-pocket medical and dental costs related to the *Lomeli, et al., v. Shewry* lawsuit.

Authority:
Not Applicable

Background:
The Department finalized a settlement of the *Lomeli* lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. In August 2011, the Department began sending notices to SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and an updated notice to new SSI recipients, informing them of the availability of retroactive coverage. Benefit costs for eligible medical services during the retroactive coverage period may qualify individuals for reimbursement.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. The Department has established the following assumptions based on previous lawsuit settlements.

2. The Department began receiving claims in October 2011, and costs began in December 2011.

3. Assume there are 1,000 Medi-Cal claims per month, of which 60% are eligible for retroactive coverage.

4. Of those, assume 33% of the claims are for dental services and 67% of the claims are for medical services.

5. It is estimated that 18% of dental claims will be approved.

LOMELI V. SHEWRY

REGULAR POLICY CHANGE NUMBER: 9

6. It is estimated that 28% of medical claims will be approved.

7. Assume the average cost is $533.74 for dental claims and $202.98 for medical claims.

FY 2011-12	TF	GF
Dental Costs	$ 133,000	$ 66,500
Medical Costs	$ 161,000	$ 80,500
Total Cost	**$ 294,000**	**$ 147,000**

FY 2012-13	TF	GF
Dental Costs	$ 228,000	$ 114,000
Medical Costs	$ 276,000	$ 138,000
Total Cost	**$ 504,000**	**$ 252,000**

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

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	8/2011
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1558

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$186,000	$464,000
- STATE FUNDS	$133,000	$318,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$186,000	$464,000
STATE FUNDS	$133,000	$318,000
FEDERAL FUNDS	$53,000	$146,000

DESCRIPTION

Purpose:
This policy change estimates the costs of changes made to the 250% Working Disabled Program (WDP).

Authority:
AB 1269 (Chapter 282, Statutes of 2009)

Background:
The WDP allows for employed individuals with disabilities to earn up to 250% of the federal poverty level (FPL) and receive full scope Medi-Cal benefits. All eligibles in this program are required to pay a monthly premium based on their countable income.

AB 1269 requires the Department to implement changes to the WDP 30 days after the American Recovery and Reinvestment Act of 2009 (ARRA) ends on June 30, 2011.

The changes made by AB 1269 are:

1. Exemption of disability income that converts to retirement income.

2. Exemption of retained income from the resource calculation when held in a separately identifiable account and not comingled with other resources.

3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.

4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.

However, under the Patient Protection and Affordable Care Act (PPACA) of 2010, Maintenance of Effort (MOE) requirements are imposed upon states until January 1, 2014. These requirements prevent states from implementing more restrictive Medicaid eligibility policies, procedures or methodologies

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 10

without jeopardizing federal funding, therefore; change #4 concerning monthly premiums will not be implemented due to the MOE provisions of PPACA.

Reason for Change from Prior Estimate:
Changes due to updated data and projections for aid code 6G.

Methodology:

1. The changes to the WDP were implemented August 1, 2011.

2. The provisions of the bill concerning retained income exemption and 26 weeks of eligibility while unemployed have an indeterminate impact.

3. The exemption of disability income that converts to retirement income will create an increase in the number of WDP participants resulting in additional costs to Medi-Cal.

4. Those affected by the exemption of disability income that converts to retirement income are age 65 and older.

5. Based on FY 2010-11 eligible data there are 510 average monthly eligibles in Aid Code 6G who are over 65 years of age.

6. The current growth rate of over 65 year olds in Aid Code 6G is 1.1% monthly or 6 beneficiaries per month (rounded). It is assumed there will be an additional increase of 70 eligibles per year to the WDP.

7. The full increase in eligibles will be phased-in over 12 months.

8. The fee-for-service (FFS) per member per month (PMPM) cost per eligible for aid code 6G is $270.97 and the average monthly managed care cost is $586.62 ($510.02 cap rate and $70.57 for carve-out PMPM cost). The monthly dental capitation rate is $6.03.

9. The monthly premium for the 2011 Medicare Part B premium is $115.40 and is estimated to be $99.90 in 2012 and 2013. The monthly premium for the Medicare Part D premium is $100.77 in 2011, and is estimated to be $102.76 in 2012 and $105.29 in 2013.

FY 2011-12	**TF**	**GF**
FFS (lagged)	$41,000	$20,500
Managed Care	$63,000	$31,500
Medicare Part B	$40,000	$40,000
Medicare Part D	$40,000	$40,000
Dental	$2,000	$1,000
Total	**$186,000**	**$133,000**

FY 2012-13	**TF**	**GF**
FFS (lagged)	$143,000	$71,500
Managed Care	$144,000	$72,000
Medicare Part B	$84,000	$84,000
Medicare Part D	$88,000	$88,000
Dental	$5,000	$2,500
Total	**$464,000**	**$318,000**

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 10

Funding:

FY 2011-12:		**GF**	**FF**	**TF**
Title XIX 50/50 FFP	4260-101-0001/0890	$ 53,000	$ 53,000	**$ 106,000**
GF	4260-101-0001	$ 80,000	$ 0	**$ 80,000**

FY 2012-13:		**GF**	**FF**	**TF**
Title XIX 50/50 FFP	4260-101-0001/0890	$ 146,000	$ 146,000	**$ 292,000**
GF	4260-101-0001	$ 172,000	$ 0	**$ 172,000**

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 1/2011
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1371

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$8,858,100	-$8,858,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$8,858,100	-$8,858,100
FEDERAL FUNDS	$8,858,100	$8,858,100

DESCRIPTION

Purpose:
This policy change estimates the technical adjustments in funding from 100% State GF to claim Title XIX or Title XXI federal match for the health care expenditures of qualified children and pregnant aliens who have not yet met the federal 5-year bar.

Authority:
Children's Health Insurance Program Reauthorization Act (CHIPRA)

Background:
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with 50% federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the US for less than five years and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services.) CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women even if they have been in the U.S. for less than five years, effective April 1, 2009. Enhanced Title XXI funding is available for children eighteen years of age and younger.

Reason for Change from Prior Estimate:
The changes are due to updated expenditures for qualified children and pregnant aliens under the 5-year bar.

Methodology:
1. Based on cost data for FY 2010-11 assume the total annual expenditures for New Qualified Aliens (NQA) children are $30,622,000 TF ($15,311,000 GF), of this amount $11,836,000 TF ($4,293,000 GF) are for non-emergency services. Of the non-emergency expenditures, $4,850,000 TF ($1,766,000 GF) is for FFS, including managed care carve-out costs, and $6,986,000 TF ($2,257,000 GF) is for managed care capitation rates.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 11

2. Based on cost data for FY 2010-11 assume the FFS expenditures for NQA pregnant women are $36,631,000, including managed care carve-out costs. 93.36% of these costs are related to pregnancy, which are currently eligible for FFP. Assume the remainder of the costs for non-pregnancy related health care services account for 6.64% of expenditures, and will be eligible for FFP under CHIPRA.

FFS	$34,763,000	x 6.64% =	$2,308,000	
Carve-Out	$1,869,000	x 6.64% =	$124,000	
		Total	$2,432,000	($1,216,000 GF)

3. Assume the Managed Care costs for NQA pregnant women are now eligible for FFP under CHIPRA. Assume the annual cost for these beneficiaries is $198,000 TF ($99,000 GF).

4. Assume the total expenditures for non-pregnancy related services for NQA pregnant women are $2,630,000 TF ($1,315,000 GF) annually.

   $2,432,000 + $198,000= $2,630,000 ($1,315,000 GF) annually

5. Assume a savings to the General Fund since the non-emergency expenditures for NQA children and pregnant women were previously budgeted at 100% GF, but are now eligible for FFP.

6. Total non-emergency costs for NQA children under the age of 19 years and non-pregnancy related services for NQA pregnant women are as follows:

FY 2011-12 & Annually	**TF**	**GF**	**FFP**
Children	$11,836,000	$4,293,000	$7,543,000
Pregnant Women	$2,630,000	$1,315,000	$1,315,000
Total (Rounded)	**$14,466,000**	**$5,608,000**	**$8,858,000**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XXI Enhanced Healthy Families FFP (4260-113-0890)
100% State GF (4260-101-0001)

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 12/1997
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 15

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$99,622,000	$99,663,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$99,622,000	$99,663,000
FEDERAL FUNDS	-$99,622,000	-$99,663,000

DESCRIPTION

Purpose:
This policy change is a technical adjustment to shift funds from Title XIX 50% federal financial participation (FFP) to 100% GF because FFP cannot be claimed for nonemergency health care expenditures for New Qualified Aliens (NQA).

Authority:
H.R. 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code, section 14007.5

Background:
PRWORA specified that FFP is not available for full-scope Medi-Cal services for most qualified nonexempt aliens who enter the country after August 1996, for the first 5 years they are in the country. They are eligible for FFP for emergency services only. As California law requires that legal immigrants receive the same services as citizens, the nonemergency services are 100% State funded.

Reason for Change from Prior Estimate:
The changes are due to updated expenditures for nonemergency services for NQAs.

Methodology:
1. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of NQAs from January 2006 through September 2011, current year and budget year costs were projected.

2. Based on the historical pattern of FFS versus managed care nonemergency service expenditures for the period of April 2009 through March 2010 (17.15%), the managed care totals for current year and budget year were projected.

3. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified aliens is included in the SCHIP Funding for Prenatal Care policy change.

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 12

4. The impact of Children's Health Insurance Program Reauthorization Act (CHIPRA) funding for full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women, even if they have been in the U.S. for less than five years, is budgeted in the CHIPRA Medi-Cal for Children and Pregnant Women policy change.

(rounded)	FY 2011-12	FY 2012-13
FFS	$ 170,069,000	$ 170,139,000
Managed Care	$ 29,175,000	$ 29,187,000
Total	$ 199,244,000	$ 199,326,000
FFP Repayment	**$ 99,622,000**	**$ 99,663,000**

Funding:
Title XIX General Fund (4260-101-0001)

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 12/1998
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 13

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$52,651,500	-$60,354,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$52,651,500	-$60,354,450
FEDERAL FUNDS	$52,651,500	$60,354,450

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding for the 100 and 133 Percentage Programs expenditures to be adjusted from Title XIX 50% FFP to enhanced Title XXI 65% FFP.

Authority:
SB 903 (Chapter 624, Statutes of 1997)

Background:
Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility for children ages one to 19 in the 100 and 133 Percent programs. This change was implemented to help streamline the application process and to align Medi-Cal eligibility more closely with the Healthy Families Program.

Effective October 1, 2012, the Healthy Families Program will cease to enroll new applicants and will be phased-out over a nine-month period. Children enrolled in the Healthy Families Program will be transitioned to the Medi-Cal Program as targeted low-income children and resources will not be counted for children with incomes up to 250% of the FPL.

Reason for Change from Prior Estimate:
The changes are due to additional caseload and expenditures.

Methodology:
1. Aid codes (8N, 8P, 8R, and 8T) that identify children eligible for Medi-Cal due to disregarding assets were implemented in December 1998.

2. Average monthly fee-for-service eligibles, which are included in the base, are estimated to be 51,299 in FY 2011-12 and 53,765 in FY 2012-13. It is assumed total FFS expenditures will be $30,335,000 in FY 2011-12 and $31,794,000 in FY 2012-13.

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 13

3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 169,667 in FY 2011-12 and 176,039 in FY 2012-13. It is assumed total Managed Care expenditures will be $320,675,000 in FY 2011-12 and $370,570,000 in FY 2012-13.

4. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2011-12 and FY 2012-13.

Funding:

FY 2011-12:		**GF**	**FF**	**TF**
Title XIX 50/50 FFP	4260-101-0001/0890	($175,505,000)	($175,505,000)	($351,010,000)
Title XXI 65/35 FFP	4260-113-0001/0890	$122,853,500	$228,156,500	$351,010,000
Net Impact		**($52,651,500)**	**$52,651,500**	**$0**

FY 2012-13:		**GF**	**FF**	**TF**
Title XIX 50/50 FFP	4260-101-0001/0890	($201,181,500)	($201,181,500)	($402,363,000)
Title XXI 65/35 FFP	4260-113-0001/0890	$140,827,000	$261,536,000	$402,363,000
Net Impact		**($60,354,500)**	**$60,354,500**	**$0**

PARIS - VETERANS MATCH

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 8/2011
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1632

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$228,000	-$742,000
- STATE FUNDS	-$114,000	-$371,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$228,000	-$742,000
STATE FUNDS	-$114,000	-$371,000
FEDERAL FUNDS	-$114,000	-$371,000

DESCRIPTION

Purpose:
This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS) Veterans Match.

Authority:
Welfare & Institutions Code, section 14124.11

Background:
PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS system includes three different data matches; PARIS-Interstate, PARIS-Federal, and PARIS-Veterans.

The PARIS-Veterans match allows the Department to improve the identification of veterans enrolled in the Medi-Cal program. Improved veteran identification enhances the Department's potential to shift health care costs from the Medi-Cal program to the United States Department of Veterans Affairs (USDVA).

Reason for Change from Prior Estimate:
Updated data showed discontinued managed care beneficiaries, which resulted in additional savings.

Methodology:
1. The Department currently is operating PARIS-Veterans in 10 counties.

2. Savings for PARIS-Veterans is for eligibles in managed care and fee-for-service (FFS).

3. It is estimated 40 veterans will discontinue their Medi-Cal benefits in FY 2011-12, of which 13 will be managed care and 27 will be FFS. It is estimated 80 veterans will discontinue their Medi-Cal benefits in FY 2012-13, of which 33 will be managed care and 47 will be FFS.

PARIS - VETERANS MATCH

REGULAR POLICY CHANGE NUMBER: 14

4. It is estimated the Department will achieve savings of $228,000 TF for FY 2011-12, and $742,000 TF for FY 2012-13.

	TF	GF
FY 2011-12	**-$228,000**	-$114,000
FY 2012-13	**-$742,000**	-$371,000

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

PARIS-INTERSTATE AND PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 10/2009
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1357

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$1,030,000	-$3,596,000
- STATE FUNDS	-$515,000	-$1,798,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,030,000	-$3,596,000
STATE FUNDS	-$515,000	-$1,798,000
FEDERAL FUNDS	-$515,000	-$1,798,000

DESCRIPTION

Purpose:
This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS)-Interstate and PARIS-Federal.

Authority:
Not applicable

Background:
PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS system includes three different data matches. The PARIS-Veterans match allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs. The PARIS-Federal match allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management to identify federal pension income or health benefits. The PARIS-Interstate match allows states to compare their beneficiary information with other states to identify beneficiary changes in residence and public assistance benefits in other states.

The Department implemented a PARIS Interstate and Federal match pilot program in FY 2009-10. The pilot program allowed the Department to identify long-term savings prior to incurring costs that would be associated with statewide implementation.

Since the launch of the pilot program Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Interstate and PARIS-Federal are implemented in 25 counties. The Department plans to expand to 40 counties in FY 2012-13.

Reason for Change from Prior Estimate:
The number of beneficiaries that will be discontinued as a result of PARIS-Interstate and PARIS-Federal matches has been reduced based on recent matches and the narrative for "Asset and Eligibility Verification" was removed because we are unable to estimate savings for it.

PARIS-INTERSTATE AND PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER: 15

Methodology:

1. Savings for PARIS-Interstate is only for eligibles in Managed Care, since it is assumed that no expenditures exist for those in fee-for-service (FFS). Savings for PARIS-Federal is assumed for both Managed Care and FFS.

2. Based on quarterly reports for August 2011 through May 2012, it is estimated 4,208 managed care and 48 FFS beneficiaries will be discontinued from Medi-Cal in FY 2011-12.

3. Based on quarterly reports for August 2011 through May 2012, it is estimated 6,502 managed care and 75 FFS beneficiaries will be discontinued from Medi-Cal in FY 2012-13.

4. Total managed care savings is estimated to be $7,552,000 TF in FY 2011-12, and $15,149,000 TF in FY 2012-13. Total FFS savings is estimated to be $934,000 TF in FY 2011-12 and $2,590,000 TF in FY 2012-13.

5. In FY 2011-12, it is estimated that 88.56% of the managed care savings and 82.26% of the FFS savings is captured in the base trends. In FY 2012-13, it is estimated that 80.52% of the managed care savings and 75.04% of the FFS savings is captured in the base trends.

FY 2011-12	**Total Savings**	**% in Base**	**Savings in Base**
Managed Care Savings	$7,552,000	88.56%	$6,688,078
FFS Savings	$934,000	82.26%	$768,306
Total	$8,486,000		$7,456,384

FY 2012-13	**Total Savings**	**% in Base**	**Savings in Base**
Managed Care Savings	$15,149,000	80.52%	$12,198,599
FFS Savings	$2,590,000	75.04%	$1,943,524
Total	$17,739,000		$14,142,123

6. Total estimated savings not in the base trends:

FY 2011-12	**TF**	**GF**
Managed Care Savings	$864,000	$432,000
FFS Savings	$166,000	$83,000
Total	**$1,030,000**	**$515,000**

FY 2012-13	**TF**	**GF**
Managed Care Savings	$2,950,000	$1,475,000
FFS Savings	$646,000	$323,000
Total	**$3,596,000**	**$1,798,000**

Funding:

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

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	7/1984
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	24

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$321,748,000	$327,635,000
- STATE FUNDS	$160,874,000	$163,817,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$321,748,000	$327,635,000
STATE FUNDS	$160,874,000	$163,817,500
FEDERAL FUNDS	$160,874,000	$163,817,500

DESCRIPTION

Purpose:
This policy change estimates the costs for the Adult Day Health Care (ADHC) services provided to beneficiaries that are at risk of institutionalization.

Authority:
Welfare and Institutions Code, Division 9, Part 3, Chapter 8.7, commencing with Section 14520

Background:
ADHC is a community-based day program providing health, therapeutic, and social services designed to serve those at risk of institutionalization. The ADHC Program is funded via the Medi-Cal budget with State General Fund and Title XIX federal funds. The California Department of Public Health (CDPH) performs the licensing of Medi-Cal ADHCs. The Department of Aging (CDA) administers the program and certifies each center for Medi-Cal reimbursement.

A moratorium on the certification of new ADHC centers has been in place since August 16, 2004, with some exceptions. Under the authority given to the Director under Welfare and Institutions Code §14043.46, this moratorium has been extended through FY 2011-12.

AB 97 eliminates ADHC services as an optional benefit under the Medi-Cal program. See the Eliminate ADHC Services for the impact of AB 97 on the ongoing estimate for ADHC services.

Reason for Change from Prior Estimate:
There is no material change.

Methodology:
1. ADHC rates are increased each year by the same percentage as the NF-A weighted average rate increase.

2. ABX4 5 (Chapter 5, Statutes of 2009), freezes rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. Therefore, no rate increase is assumed for rate year 2011-12 or 2012-13.

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER: 16

3. The estimated average monthly cost per ADHC user is expected to be $908.00 for FY 2011-12 and $932.00 for FY 2012-13. This is based on paid claims data through February 2012.

4. The projected average monthly users for FY 2011-12 are 29,529.

5. The projected average monthly users for FY 2012-13 are 29,295.

6. The projected costs for FY 2011-12 and FY 2012-13 are:

   FY 2011-12: 29,529 x 12 months x $908.00 = **$321,748,000 TF ($160,874,000 GF)**

   FY 2012-13: 29,295 x 12 months x $932.00 = **$327,635,000 TF ($163,817,500 GF)**

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

ADDITIONAL SERVICES FOR HCBS CLIENTS

REGULAR POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 8/2012
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1476

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$651,423,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$651,423,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$651,423,000

DESCRIPTION

Purpose:
This policy change estimates the federal match to the Department of Developmental Services for the additional services provided to Home and Community Based Services (HCBS) clients.

Authority:
Interagency Agreement (IA)

Background:
In December 2009, the Department submitted to the Centers for Medicare and Medicaid Services (CMS) a 1915(i) HCBS state plan amendment (SPA) to include certain services provided by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC clients who have previously received or currently receive certain services will continue to be eligible for these services even though they do not meet the institutional level of care requirements for the HCBS waiver for persons with developmental disabilities. Services scheduled for coverage under this SPA include: habilitation, respite care, personal care services, homemaker services, home health aide services, and adult day health care. It is anticipated that the SPA will be approved in FY 2012-13, with a retroactive effective date of October 1, 2009. Non-emergency medical transportation and services for adults, which were eliminated from the Medi-Cal scope of services, were included in an amendment to this SPA in FY 2010-11.

A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011.

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 Federal Financial Participation (FFP) for FY 2011-12 and FY 2012-13.

ADDITIONAL SERVICES FOR HCBS CLIENTS

REGULAR POLICY CHANGE NUMBER: 17

The budgeted amount for FY 2012-13 includes expenditures for the retroactive period of October 1, 2009 through June 30, 2012.

Reason for Change from Prior Estimate:
Pending federal approval has delayed implementation.

Methodology:

(In Thousands)	Total Funds	CDDS GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2012-13	$1,192,059	$540,636	$596,030	$55,393	**$651,423**	Pending

Funding:
Title XIX FFP (4260-101-0890)

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2011
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1594

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$278,422,000	$309,744,000
- STATE FUNDS	$139,211,000	$154,872,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$278,422,000	$309,744,000
STATE FUNDS	$139,211,000	$154,872,000
FEDERAL FUNDS	$139,211,000	$154,872,000

DESCRIPTION

Purpose:
This policy change estimates the benefits costs associated with transitioning current Adult Day Health Care (ADHC) program participants into Community-Based Adult Services (CBAS) or other services appropriate to their needs in order to minimize the risks of institutionalization.

Authority:
AB 97 (Chapter 3, Statutes of 2011)
Settlement agreement

Background:
AB 97 eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et. al. v. Toby Douglas, et. al.*, sought to challenge the elimination of ADHC services. A settlement of the lawsuit was reached that establishes the new CBAS program. The Legislature appropriated $170 million TF ($85 million GF) to the Department to help transition existing ADHC enrollees to other appropriate Medi-Cal services. The funds may be used for assessment, placement, and the provision of services. The ADHC ongoing estimate and the effect of the July 1, 2011 termination are found in the Adult Day Health Care – CDA and Eliminate ADHC services policy changes.

The fiscal intermediary cost of the transition is included in the fiscal intermediary section of the Estimate. The other administration costs of the transition are included in the ADHC Transition – Administration policy change.

Reason for Change from Prior Estimate:
Benefits costs changed because of the extension of the ADHC benefit for one additional month (March 2012). Also, there was an increase in CBAS caseload due to patient assessments. The shift of eligibles into managed care is no longer included in this PC because the impact is included in the managed care base policy changes. The reasons for changes in administrative costs are included in the ADHC Transition – Administration policy change.

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER: 18

Methodology:
Transition activities include:

Nine-month Extension of Services—The termination of coverage of ADHC services was delayed for nine months, from July 1, 2011, to April 1, 2012. This allowed the time to implement a multi-faceted approach to provide comprehensive health risk assessments, care coordination, case management and appropriate ongoing services to former ADHC clients.

CBAS—Effective April 1, 2012, this new, smaller, and more targeted program will be created for those former ADHC clients who are most in need of medical and social services. Based upon preliminary data, the average monthly caseload is expected to be 28,000. As additional information becomes available, this caseload estimate may be revised. For those eligible for enrollment in Medi-Cal managed care plans, these services will be covered only through the plans, no sooner than July 1, 2012.

Discharge Planning—The transition began with individualized discharge planning and the completion of the ADHC individual plan of care by ADHCs before the benefit was scheduled to end. The Department reimbursed ADHCs for these additional costs (one-time reimbursement per assessment submitted).

Health Care Options (HCO) Cost—The HCO contractor, Maximus, assists ADHC clients enrolling into managed care plans by preparing and mailing informational notices and making proactive phone calls. These costs are shown in the Fiscal Intermediary (FI) Estimate.

FFS Assessment and Care Coordination—For those ADHC clients in counties without managed care or when the client chooses FFS rather than managed care, the Department has contracted with APS, Inc., to provide health risk assessment, care coordination, and case management. Additionally, APS assisted with the ADHC clients who enrolled in managed care in Los Angeles County as well as Health Net plans in October 2011 and November 2011. APS will assist the Department with ADHC/CBAS assessments through February 2012.

In-Home Supportive Services (IHSS) Administration—These are the administrative costs provided to the California Department of Social Services for reassessing ADHC clients for IHSS eligibility.

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER: 18

(In Thousands)	FY 2011-12		FY 2012-13	
Benefits Cost	TF	GF	TF	GF
Nine Month Extension	$244,326	$122,163	$ 21,318	$ 10,659
CBAS	$ 33,806	$ 16,903	$288,426	$144,213
Discharge Planning	$ 290	$ 145	$ -	$ -
Total Benefits	**$278,422**	**$139,211**	**$309,744**	**$154,872**
HCO (included in FI Estimate)	$ 2,342	$ 1,171	$ -	$ -
Other Administration Cost				
FFS Assessment & Care Coordination	$ 7,888	$ 3,944	$ 1,800	$ 900
IHSS Administration	$ 3,500	$ 1,750	$ -	$ -
Total Other Administration	$ 11,388	$ 5,694	$ 1,800	$ 900
Total All Costs	$ 292,152	$146,076	$311,544	$155,772

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 7/2000
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 25

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$117,810,000	$115,122,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$117,810,000	$115,122,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$117,810,000	$115,122,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services.

Authority:
Welfare & Institutions Code, section 14132.06

Background:
LEAs, which consist of school districts, county offices of education, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA Medi-Cal Billing Option Program. Through the program, LEAs submit claims for reimbursement for specific eligible health services provided to Medi-Cal eligible students. The LEAs submit a Cost and Reimbursement Comparison Schedule (CRCS) to the Department annually to compare each LEA's total actual costs for reimbursed Medi-Cal eligible services for the preceding fiscal year. These benefits are provided to the extent federal financial participation (FFP) is available. The Department is currently performing audits to reconcile the cost reports with payments for fiscal years 2006-07, 2007-08 and 2008-09.

Reason for Change from Prior Estimate:
No material change.

Methodology:
1. 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. 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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 19

applicable FMAP based on date of service, such as LEAs payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

3. Analysis of actual payments based on paid claims reports for FY 2011-12 and historical claims submitted by school districts and county offices of education enrolled as Medi-Cal providers for medical assistance they deliver to Medi-Cal eligible students provides the basis for the projected expenditures plus an adjustment for ARRA step down.

(In Thousands)	FFP Regular	FFP ARRA	FFP Total
FY 2011-12	$101,155	$16,655	**$117,810**
FY 2012-13	$109,124	$5,998	**$115,122**

Funding:
Title XIX FFP (4260-101-0890)

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/1984
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 28

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$40,464,000	$39,614,000
- STATE FUNDS	$20,232,000	$20,232,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,464,000	$39,614,000
STATE FUNDS	$20,232,000	$20,232,000
FEDERAL FUNDS	$20,232,000	$19,382,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the Multipurpose Senior Services Program (MSSP) and for the General Fund (GF) reimbursement to the Department.

Authority:
Welfare and Institutions Code, section 9560-9568

Background:
The MSSP provides a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care but who wish to remain in the community. The program provides services under a federal home and community-based services (HCBS) waiver for up to 16,335 clients in 11,789 client slots, at $4,285 per year per client slot.

SB 87 (Chapter 33, Statutes of 2011) reduced the operational costs of the MSSP program. The budgeted amount for FY 2011-12 and 2012-13 includes savings from a permanent reduction made to the MSSP. The GF is budgeted in the California Department of Aging (CDA) budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay MSSP claims.

Beginning March 1, 2013, the Department will transition care for dual eligibles who receive Long-Term Care (LTC) institutional services, In-Home Supportive Services (IHSS) and other HCBS to managed care health plans. Under this proposal, managed care capitation will include IHSS services to the MSSP population, therefore, a reduction of federal financial participation (FFP) is reflected in FY 2012-13 for MSSP costs, that will included in the managed care capitated rates beginning March 1, 2013. See policy change Transition of Dual Eligibles-Long Term Care.

Reason for Change from Prior Estimate:
There is a decrease in FY 2012-13 as MSSP costs paid to IHSS providers will be funded through managed care capitated rates beginning March 1, 2013.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 20

Methodology:

CASH BASIS (In Thousands) **FY 2011-12**	**TF**	**Reimbursement from CDA**	**Regular FFP**
MSSP	**$40,464**	**$20,232**	**$20,232**

FY 2012-13	**TF**	**Reimbursement from CDA**	**Regular FFP**
MSSP	**$39,614**	**$20,232**	**$19,382**

Funding:
Title XIX FFP (4260-101-0890)
Reimbursement (4260-610-0995)

MFP FUNDING TO CDDS AND CDSS FOR CCT

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 10/2011
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1562

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$3,587,000	$2,100,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,587,000	$2,100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,587,000	$2,100,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental federal funding associated with providing the California Department of Developmental Services (CDDS) and California Department of Social Services (CDSS) additional Title XIX for waiver services provided to Medi-Cal beneficiaries who participate in the California Community Transitions (CCT) project.

Authority:
Federal Deficit Reduction Act of 2005, section 6071
Affordable Care Act (ACA)

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition to federally-allowed home and community-based settings.

Reason for Change from Prior Estimate:
The estimated expenditures were reduced due to delayed implementation of an interagency agreement with CDSS and caseload adjustment for CDDS.

Methodology:
1. The Department provides Home and Community Based Services (HCBS) to developmentally disabled CCT participants and CCT participants who are receiving In-Home Supportive Services (IHSS). The Department provides federal funding to CDDS and CDSS as the base federal match through HCBS policy changes.

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDDS is budgeted in a separate base policy change Home & Community Based Svcs.-CDDS. The GF for CDSS is provided by CDSS and is budgeted in base policy change Personal Care Services (Misc. Svcs.).

MFP FUNDING TO CDDS AND CDSS FOR CCT

REGULAR POLICY CHANGE NUMBER: 21

3. This policy change budgets the difference between the regular Federal Medical Assistance Percentage (FMAP) and the enhanced FMAP for eligible Medi-Cal beneficiaries participating in CCT. In FY 2010-11, the Department established Interagency Agreement (IA) 09-86345 with CDDS and in FY 2011-12 IA 10-87274 was established with CDSS. These IAs transfer additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.

   Estimated Costs:

	FY 2011-12	FY 2012-13
CDSS	$780,000	$600,000
CDDS	$2,798,000	$1,500,000
Total	**$3,578,000**	**$2,100,000**

Funding:
100% MFP Federal Grant (4260-106-0890)

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	12/2008
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1228

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$6,958,000	$12,704,000
- STATE FUNDS	$1,739,000	$3,176,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	59.86 %	25.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,792,900	$9,528,000
STATE FUNDS	$698,030	$2,382,000
FEDERAL FUNDS	$2,094,910	$7,146,000

DESCRIPTION

Purpose:
This policy change estimates the costs of transitioning beneficiaries who have resided in health care facilities to federally-allowed home and community based settings (HCBS). It also estimates the costs for providing demonstration services to Medi-Cal eligible beneficiaries enrolled in the California Community Transitions (CCT) Demonstration Project.

Authority:
Federal Deficit Reduction Act of 2005, section 6071
Affordable Care Act (ACA)

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under the Federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. It is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into federally-allowed HCBS. The revised award is $104 million in federal funds.

Participants are enrolled in the demonstration for a maximum of 12 months. Enrollment began December 1, 2008. Target enrollment for the period of July 1, 2011 through June 30, 2012 is 314 individuals and 360 individuals for July 1, 2012 through June 30, 2013.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD waiver beneficiaries expected to enroll into CCT is being included in this policy change, but their expenditures are budgeted in the MFP Funding to California Department of Developmental Services (CDDS) for CCT and the Home and Community Based Svcs. – CDDS policy changes.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 22

Reason for Change from Prior Estimate:
There is an increase in the number of estimated enrollees into the CCT demonstration for current year and budget year based on Department projections. Changes were also made to the methodology: 1) Assumption 1, NF B costs update; 2) Assumption 2, waiver costs increase; 3) 100% CCT participants will receive demonstration services.

Methodology:

1. Assume estimated costs for persons residing year-round in Nursing Facility (NF)-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be $61,081.

2. Assume waiver costs will be capped at $57,120 for those beneficiaries transitioning from NF-B level of care.

3. Assume all CCT services are reimbursed at 75% FFP and 25% GF. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

4. Assume 100% of CCT participants will receive demonstration services.

5. Assume demonstration services cost $7,500 per participant.

6. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change, see MFP Funding to CDDS and CDSS for CCT for more information. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.

7. Costs in the budget year include phased-in and lagged payments from the current year.

	2011-12		2012-13	
	TF	**GF**	**TF**	**GF**
Lagged savings	($8,288,000)	($4,144,000)	($13,251,000)	($6,625,500)
Lagged costs	**$6,958,000**	**$1,739,500**	**$12,704,000**	**$3,176,000**
Net (rounded)	($1,330,000)	($2,404,500)	($547,000)	($3,449,500)

Funding:
GF (4260-101-0001)
MFP Federal Grant (4260-106-0890)

QUALITY OF LIFE SURVEYS FOR MFP

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 7/2010
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1550

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$79,000	$123,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$79,000	$123,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$79,000	$123,000

DESCRIPTION

Purpose:
This policy change estimates the expenditures for the cost of completed Quality of Life (QoL) surveys administered to all California Community Transitions (CCT) enrollees.

Authority:
The CCT demonstration is administered under the federal authority of Section 6071 of the Deficit Reduction Act (DRA) of 2005, Money Follows the Person (MFP) Rebalancing Demonstration (P.L. 109-171).

Background:
The Centers for Medicare and Medicaid Services (CMS) requires the Department to conduct QoL surveys with participants in the MFP Rebalancing Demonstration project called the CCT project. QoL surveys are given within specified timeframes and methodology. MFP provider agencies, which are Medi-Cal HCBS waiver providers, conduct QoL surveys designed for the following situations:

1. Baseline QoL-Conducted before transition or within 10 days after the initial transition.
2. First Follow-up QoL-Conducted 11-12 months after the initial transition.
3. Second Follow-up-Conducted 24 months after initial transition.

The QoL surveys were designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.

Reason for Change from Prior Estimate:
Increased costs in FY 2012-13 are due an increase in CCT caseload and delay in receiving invoices.

Methodology:
1. In FY 2010-11, 285 beneficiaries were enrolled in the CCT demonstration project and 289 additional beneficiaries will enroll into CCT in FY 2011-12 and 300 in FY 2012-13.

QUALITY OF LIFE SURVEYS FOR MFP

REGULAR POLICY CHANGE NUMBER: 23

2. Assume the QoL surveys are administered to all CCT enrollees twice and once again approximately one year after they have been living in community settings. Assume first follow-up QoLs are conducted 11 months after the initial transition.

3. Assume the Department reimburses $100 per completed survey for survey administration. The QoL surveys began in July 2010.

4. Assume 360 eligible participants completed only one survey in FY 2011-12 and 400 in FY 2012-13.

360 x $100 = $36,000 Baseline
285 x $100 = $28,500 First follow up
145 x $100 = $14,500 Second follow up

FY 2011-12 Estimated Costs: **$79,000 TF**

400 x $100 = $40,000 Baseline
290 x $100 = $29,000 First follow up
285 x $100 = $28,500 Second follow up
240 x $100 = $25,400 Baseline, first and second follow ups administered by CDSS during April 2009 through June 2011.

FY 2012-13 Estimated Costs: **$123,000 TF**

Funding:
100% Federal Fund MFP Grant (4260-106-0890)

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1436

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$752,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$752,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$752,000

DESCRIPTION

Purpose:
This policy change estimates the Federal Financial Participation (FFP) provided for the City and County of San Francisco Community-Living Support Benefit Waiver (SF CLSB).

Authority:
AB 2968 (Chapter 830, Statutes of 2006)

Background:
In the proposed new waiver, the Department is working with the SF Department of Public Health to propose service delivery under a 1915(c) Home and Community Based (HCBS) Waiver. The waiver application is pending with CMS. This benefits Medi-Cal beneficiaries who are 21 years of age and older, residing in the City and County of San Francisco and who would otherwise reside in nursing facilities or be rendered homeless.

Eligible participants will have full-scope Medi-Cal eligibility or share-of-cost Medi-Cal for services to be rendered when residing in Residential Care Facilities for the Elderly (RCFEs) or in residency units made available by the Direct Access to Housing (DAH) program. Under the SF CLSB Waiver, participants will be eligible for the following services:

- Community-living support benefits in licensed settings and in housing sites
- Care coordination
- Environmental accessibility adaptations
- Home-delivered meals
- Behavior assessment and planning

Reason for Change from Prior Estimate:
There is a delay in implementation due to developing processes and financing methodology.

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 24

Methodology:

1. The waiver has a maximum capacity of 486 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment will begin in July 2012. Target enrollment for the period of July 1, 2012 through June 30, 2013 is 221 individuals.

2. The annual total cost is estimated to be $28,644 per participant in FY 2012-13.

3. The Department will utilize Certified Public Expenditures (CPE) from the City and County of San Francisco to match the federal funds for this waiver. Assume a four-month payment lag due to the utilization of CPEs. This policy change budgets the FFP only.

4. Assume State Plan services will remain constant, but to the extent beneficiaries enroll into the waiver from skilled nursing facilities, there may be GF savings to the Medi-Cal program.

Funding:

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

INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1557

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	-$9,535,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	-$9,535,200
FEDERAL FUNDS	$0	$9,535,200

DESCRIPTION

Purpose:
This policy change estimates the savings to the General Fund due to the increased federal matching rate of eligible family planning services and supplies.

Authority:
Welfare and Institutions Code, Section 14132(aa)

Background:
In September 2010, the Department requested that CMS approve a State Plan Amendment (SPA) to replace the Family Planning, Access, Care and Treatment (FPACT) Waiver in accordance with the Federal Patient Protection and Affordable Care Act. The SPA was approved on March 24, 2011. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund will receive a 90% federal matching rate, and family planning-related services will receive reimbursement at the State's regular Federal Medical Assistance Percentage (FMAP) rate effective retroactively to July 1, 2010.

Reason for Change from Prior Estimate:
The Fiscal Intermediary (FI) backlog has delayed the implementation of the new FPACT reimbursement rates. As a result, savings for FY 2011-12 were shifted to FY 2012-13.

Methodology:
1. Assume a retroactive SPA implementation date of July 1, 2010.

2. Costs for eligible family planning services and supplies which were previously paid with 100% GF will now be claimed at 90%, and costs for family planning-related services at 50% FFP.

3. Based on FY 2009-10 data, costs for eligible family planning services and supplies were $3,969,000 GF, and costs for family planning-related services were $2,391,000 GF, for a total cost of $6,360,000 GF.

INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 25

Total Cost		**New FFP**
$3,969,000 x 90%	=	$3,572,000
$2,391,000 x 50%	=	$1,195,000
$6,360,000		**$4,767,000**

4. With enhanced funding, costs for these services and supplies will be $4,767,000 FFP and $1,592,000 GF for a GF savings of $4,767,000 annually.

5. FY 2011-12 savings of $4,767,000 have been shifted to FY 2012-13. As a result, total GF savings for FY 2012-13 are $9,534,000.

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)
GF (4260-101-0001)

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 7/2005
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1007

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$88,970,050	-$92,041,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$88,970,050	-$92,041,950
FEDERAL FUNDS	$88,970,050	$92,041,950

DESCRIPTION

Purpose:
This policy change estimates the savings from the State Children's Health Insurance Program's (SCHIP) federal funding for prenatal care for women previously ineligible for federal funding.

Authority:
AB 131 (Chapter 80, Statutes of 2005)

Background:
In order to maximize revenues, AB 131 required Managed Risk Medical Insurance Board (MRMIB) to file a State Plan Amendment (SPA) to claim 65% SCHIP federal funding for prenatal care for undocumented women, and legal immigrants who have been in the country for less than five years. Previously, these costs for prenatal care were funded with 100% General Fund.

Reason for Change from Prior Estimate:
The changes are due to updated data and projections for undocumented women and legal immigrants.

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $130,414,000 in FY 2011-12 and $135,128,000 in FY 2012-13.

2. Based on the estimated costs and 65% SCHIP FFP, the following amounts are budgeted for FY 2011-12 and FY 2012-13:

FY 2011-12:	$130,414,000 x .65 =	$84,769,000 FFP
FY 2012-13:	$135,128,000 x .65 =	$87,833,000 FFP

3. The estimated prenatal care cost for legal immigrants, who have been in the country for less than five years, is $6,463,000 for FY 2011-12 and $6,475,000 for FY 2012-13.

FY 2011-12:	$6,463,000 x .65 SCHIP FFP =	$4,201,000 FFP
FY 2012-13:	$6,475,000 x .65 SCHIP FFP =	$4,209,000 FFP

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 26

4. The federal funding received on a cash basis will be:

FY 2011-12 Savings:	$84,769,000 + $4,201,000 =	**$88,970,000**
FY 2012-13 Savings:	$87,833,000 + $4,209,000 =	**$92,042,000**

Funding:
Title XXI 35/65 FFP (4260-113-0001/0890)
GF (4260-101-0001)

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 5/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1515

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$92,000	-$764,000
- STATE FUNDS	-$46,000	-$382,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$92,000	-$764,000
STATE FUNDS	-$46,000	-$382,000
FEDERAL FUNDS	-$46,000	-$382,000

DESCRIPTION

Purpose:
This policy change estimates the savings associated with applying a benefit cap for hearing aids provided under the Medi-Cal program.

Authority:
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, section 14131.05

Background:
AB 97 enacted a $1,510 cap on hearing aids expenditures per beneficiary. Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair (binaural). The hearing aid cap is for adults 21 years of age or older who are not residing in a long-term care facility, pregnant, or a Family Planning, Access, Care and Treatment (FPACT) program beneficiary.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. Assume savings will begin May 1, 2012.

2. Actual annual hearing aid expenditures for FY 2009-10 were $20,186,000 for 24,762 unduplicated users.

3. Of the annual hearing aid expenditures amount, $1,547,000 were associated with beneficiaries residing in long-term care and pregnant women, and $2,015,000 were associated with beneficiaries under 21 years of age.
   $1,547,000 + $2,015,000 = $3,562,000

4. Expenditures subject to cap are: $20,186,000 - $3,562,000 = $16,624,000

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 27

5. Based on paid claims for hearing aids for dates of service between July 1, 2009 and June 30, 2010, total FFS hearing aids expenditures below the $1,510 cap were $8,643,000 for 14,201 beneficiaries. Based on this data an average $1,580 is spent annually per beneficiary at and above the $1,510 expenditure cap.

	Users	Expenditures
Total unduplicated users	24,762	$20,186,000
LTC, children, & pregnant women	5,510	$3,562,000
Expenditures subject to cap	19,252	$16,624,000
Below the $1,510 cap for adults	14,201	$8,642,000
Above the $1,510 cap for adults	5,051	$7,982,000

(In Thousands)	TF	GF	FFP
Annual FFS Expenditures	$20,186	$10,093	$10,093
LTC, children, & pregnant women	-$3,562	-$1,781	-$1,781
Expenditures Subject to Cap	$16,624	$8,312	$8,312
FFS Expenditures < $1,510 cap	-$8,642	-$4,321	-$4,321
FFS Expenditures > $1,510 cap	$7,982	$3,991	$3,991
Allowable costs for > the $1,510 cap	-$7,627	-$3,814	-$3,814
Annual FFS savings due to cap	$355	$177	$178
Annual Managed Care savings due to cap	$440	$220	$220
Total Annual Savings	$795	$397	$398
FY 2011-12			
FFS (lagged)	$19	$9	$10
Managed Care	$73	$37	$36
Total FY 2011-12	**$92**	**$46**	**$46**
FY 2012-13			
FFS (lagged)	$324	$162	$162
Managed Care	$440	$220	$220
Total FY 2012-13	**$764**	**$382**	**$382**

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

DISCONTINUE PART B PREMIUM FOR UNMET SOC BENES

REGULAR POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 9/2011
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1506

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$218,000	-$246,000
- STATE FUNDS	-$218,000	-$246,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	72.03 %	57.24 %
APPLIED TO BASE		
TOTAL FUNDS	-$61,000	-$105,200
STATE FUNDS	-$60,970	-$105,190
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the savings due to eliminating payments of Medicare Part B premiums for those beneficiaries with an unmet share of cost (SOC) of $500 or less.

Authority:
The SB 853 (Chapter 717, Statutes of 2010) eliminates the payment of Medicare Part B premiums for those beneficiaries with an unmet SOC of $500 or less.

Background:
This change was implemented September 1, 2011. Premium payments for beneficiaries with unmet SOCs greater than $500 were eliminated effective December 1, 2008.

Reason for Change from Prior Estimate:
Medicare reduced the Part B premiums effective January 1, 2012.

Methodology:
1. Implementation and savings began September 2011.

2. Part B premiums are $115.40 per month per beneficiary from July through December 2012. Premiums are estimated to be $99.90 per month per beneficiary from January through June 2013.

3. Based on the most recent 12 months of SOC data, an average of 205 beneficiaries each month had a SOC less than $500 and did not meet their SOC.

4. The FY 2011-12 savings are estimated to be $218,000.

   205 x 4 months x $115.40 =$ 95,000 GF
   205 x 6 months x $99.90 =$123,000 GF

DISCONTINUE PART B PREMIUM FOR UNMET SOC BENES

REGULAR POLICY CHANGE NUMBER: 28

5. FY 2012-13 savings is estimated to be $246,000 GF.

   205 x 12 months x $99.90 =$246,000 GF

FY 2011-12		FY 2012-13	
TF	**GF**	**TF**	**GF**
$218,000	**$218,000**	$246,000	**$246,000**

Funding:
General Fund (4260-101-0001)

ELIMINATION OF OTC COUGH AND COLD PRODUCTS

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	3/2012
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1575

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$1,264,000	-$4,421,000
- STATE FUNDS	-$632,000	-$2,210,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,264,000	-$4,421,000
STATE FUNDS	-$632,000	-$2,210,500
FEDERAL FUNDS	-$632,000	-$2,210,500

DESCRIPTION

Purpose:
This policy change estimates the savings from the elimination of over-the-counter (OTC) cough and cold products as Medi-Cal benefits.

Authority:
AB 97 (Chapter 33, Statutes of 2011)

Background:
AB 97 eliminated selected nonprescription cough and cold products as Medi-Cal benefits for adults and children. Children eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) are exempt from this provision.

Reason for Change from Prior Estimate:
The estimated savings decreased as a result of a delay in implementation. The Department had to await the Centers for Medicare and Medicaid Services approval of the OTC cough and cold reduction State Plan Amendment.

Methodology:
1. The legislation was enacted on March 24, 2011, and savings are expected to begin on March 1, 2012.

2. Fee-for-service expenditures for nonprescription cough and cold products for adults and children are estimated to be $3,762,000 annually.

3. Managed care savings are estimated to be $670,000 annually.

ELIMINATION OF OTC COUGH AND COLD PRODUCTS

REGULAR POLICY CHANGE NUMBER: 29

4. Annual savings are estimated to be: $3,762,000 + $670,000 = $4,432,000 TF

FY 2011-12 Savings:	**TF**	**GF**
FFS (Lagged)	$1,041,000	$ 520,500
Managed Care	$ 223,000	$ 111,500
Total FY 2011-12	**$1,264,000**	**$ 632,000**

FY 2012-13 Savings:	**TF**	**GF**
FFS (Lagged)	$3,751,000	$1,875,500
Managed Care	$ 670,000	$ 335,000
Total FY 2012-13	**$4,421,000**	**$2,210,500**

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

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1519

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	-$44,955,000
- STATE FUNDS	$0	-$22,477,500
PAYMENT LAG	1.0000	0.8346
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$37,519,400
STATE FUNDS	$0	-$18,759,720
FEDERAL FUNDS	$0	-$18,759,720

DESCRIPTION

Purpose:
This policy change estimates the savings from implementing an annual seven physician visit cap for Medi-Cal beneficiaries.

Authority:
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, Section 14131.07

Background:
AB 97 caps the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary at seven per year. The cap on the number of physician and clinic visits is for adults 21 years of age or older, except those who are Family Planning, Access, Care and Treatment (FPACT) program beneficiaries. The Department concluded that any changes in the managed care utilization would be minimal and any savings from a utilization decrease would be offset by increased administrative costs for the plans and providers. Consequently, the cap applies only to fee-for-service (FFS) settings.

Reason for Change from Prior Estimate:
A delay in implementation to July 1, 2012 due to State Plan Amendment (SPA) revisions and extension of anticipated time needed for implementation after federal approvals are received.

Methodology:
1. AB 97 was enacted March 24, 2011, and savings will begin on July 1, 2012.

2. The annual physician visit cap is set at seven visits per beneficiary. All visits above the seven allowed will require a physician's certification to be paid by Medi-Cal.

3. In FY 2009-2010, the number of FFS beneficiaries with 8 or more physician visits was 342,361 and their total number of physician visits was 5,010,363. The average number of visits per beneficiary was 15.

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 30

4. Medi-Cal will pay for up to seven visits per beneficiary:
   342,361 beneficiaries x 7 allowable visits = 2,396,527 allowable visits

5. The number of visits above the cap is estimated to be:
   5,010,363 total visits – 2,396,527 allowable visits = 2,613,836 visits above the cap

6. The average cost per visit is $114.66. The total annual cost above the cap is estimated to be $299,702,000.
   2,613,836 visits above the cap x $114.66 = $299,702,000

7. Assume that 85% of the visits above the cap will meet the physicians' certification requirement, and the remaining 15% will be eliminated.

8. FFS annual savings are estimated to be:
   $299,702,000 cost above the cap x 15% = $44,955,000 TF ($22,477,500 GF)

Annual Savings:	**TF**	**GF**
FFS	$44,995,000	$22,477,500

FY 2012-13 Savings:	**TF**	**GF**
FFS (Lagged)	**$37,520,000**	**$18,760,000**

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

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 12/2008
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1222

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$8,288,000	-$13,251,000
- STATE FUNDS	-$4,144,000	-$6,625,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	54.80 %	25.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,746,200	-$9,938,200
STATE FUNDS	-$1,873,090	-$4,969,120
FEDERAL FUNDS	-$1,873,090	-$4,969,120

DESCRIPTION

Purpose:
This policy change estimates the savings from Medi-Cal eligible beneficiaries who have resided in health care facilities and transitioned to federally-allowed home and community based settings (HCBS). These beneficiaries are also enrolled in the California Community Transitions (CCT) Demonstration Project.

Authority:
Federal Deficit Reduction Act of 2005, section 6071
Affordable Care Act (ACA)

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under the Federal Deficit Reduction Act of 2005 and was extended by the Patient Protection and Affordable Care Act. It is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into federally-allowed HCBS. The revised award is $104 million in federal funds.

Participants will be enrolled in the demonstration for a maximum of 12 months. Target enrollment for the period of July 1, 2011 through June 30, 2012 is 314 individuals, and 360 individuals for July 1, 2012 through June 30, 2013.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD waiver beneficiaries expected to enroll into CCT is being included in this policy change, but their expenditures are budgeted in the MFP Funding to California Department of Developmental Services (CDDS) for CCT and the Home and Community Based Svcs. – CDDS policy changes.

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 31

Reason for Change from Prior Estimate:
There is an increase in estimated enrollees into the CCT demonstration for current year and budget year based on Department projections. The increased number of transitions from nursing facilities to CCT impacts the savings reflected in this policy change.

Methodology

1. Assume estimated costs for persons residing year-round in Nursing Facilities – Level B (NF-B), pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be $61,081.

2. Assume waiver costs will be capped at $57,120 for those beneficiaries transitioning from NF-Bs.

3. Assume CCT services are reimbursed at 75% FFP and 25% GF. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

4. Assume 100% of CCT participants will receive demonstration services.

5. Assume demonstration services cost $7,500 per participant.

6. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.

	2011-12		2012-13	
	TF	GF	TF	GF
Lagged savings	**($8,288,000)**	**($4,144,000)**	**($13,251,000)**	**($6,625,500)**
Lagged costs	$6,958,000	$1,739,500	$12,704,000	$3,176,000
Net (rounded)	($1,330,000)	($2,404,500)	($547,000)	($3,449,500)

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

ELIMINATION OF OTC ACETAMINOPHEN DRUGS

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	4/2011
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1512

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$8,959,000	-$8,997,000
- STATE FUNDS	-$4,479,500	-$4,498,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	83.33 %	85.26 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,493,500	-$1,326,200
STATE FUNDS	-$746,730	-$663,080
FEDERAL FUNDS	-$746,730	-$663,080

DESCRIPTION

Purpose:
This policy change estimates the savings from the elimination of over-the-counter (OTC) acetaminophen drugs.

Authority:
SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code, section 14132 (d)(4)(A)(ii)

Background:
SB 853 eliminated specific nonprescription acetaminophen-containing products as Medi-Cal benefits for adults.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. Savings began in April 2011.

2. Fee-for-service expenditures for nonprescription acetaminophen-containing products for adults are estimated to be $7,638,000 annually.

3. Managed care savings are estimated to be $1,359,000 annually.

4. Annual savings are estimated to be:
   $7,638,000 + $1,359,000 = $8,997,000 TF

FY 2011-12 Savings:	TF	GF
FFS (Lagged)	$7,600,000	$3,800,000
Managed Care	$1,359,000	$ 680,000
Total FY 2011-12	**$8,959,000**	**$4,480,000**

ELIMINATION OF OTC ACETAMINOPHEN DRUGS

REGULAR POLICY CHANGE NUMBER: 32

FY 2012-13 Savings:	TF	GF
FFS	$7,638,000	$3,819,000
Managed Care	$1,359,000	$ 680,000
Total FY 2012-13	**$8,997,000**	**$4,499,000**

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

LIMIT ENTERAL NUTRITION TO TUBE FEEDING

REGULAR POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	10/2011
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1513

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$20,224,000	-$29,277,000
- STATE FUNDS	-$10,112,000	-$14,638,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	72.03 %	57.24 %
APPLIED TO BASE		
TOTAL FUNDS	-$5,656,700	-$12,518,800
STATE FUNDS	-$2,828,330	-$6,259,420
FEDERAL FUNDS	-$2,828,330	-$6,259,420

DESCRIPTION

Purpose:
This policy change estimates the savings from limiting enteral nutrition to tube feeding.

Authority:
AB 97 (Chapter 3, Statutes of 2011)

Background:
AB 97 limited enteral nutrition products to those products to be administered through a feeding tube. Beneficiaries under Early Periodic Screening, Diagnosis and Treatment (EPSDT) are exempt. The Department deems enteral nutrition products, not administered through a feeding tube, a benefit for patients. Patient diagnoses that include, but are not limited to, malabsorption syndromes and inborn errors of metabolism are eligible for this benefit.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. The legislation was enacted March 24, 2011, and the limitation on enteral nutrition products was implemented on October 1, 2011.

2. Fee-for-service expenditures for enteral nutrition products for adults are approximately $32,777,000 annually.

3. Of this amount, expenditures for tube-fed adults are approximately $3,885,000 annually.

4. The FFS savings is estimated to be:

$32,777,000
-$ 3,885,000
$28,892,000 TF ($14,446,000 GF) annual FFS savings

LIMIT ENTERAL NUTRITION TO TUBE FEEDING

REGULAR POLICY CHANGE NUMBER: 33

5. The managed care savings is estimated to be $385,000 TF ($192,500 GF) annually.

FY 2011-12 Savings:	TF	GF
FFS (Lagged)	$19,935,000	$ 9,967,500
Managed Care	$ 289,000	$ 144,500
Total FY 2011-12	**$20,224,000**	**$10,112,000**

FY 2012-13 Savings:	TF	GF
FFS (Lagged)	$28,892,000	$14,446,000
Managed Care	$ 385,000	$ 192,500
Total FY 2012-13	**$29,277,000**	**$14,638,500**

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

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 1/2013
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1524

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	-$14,291,000
- STATE FUNDS	$0	-$7,145,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$14,291,000
STATE FUNDS	$0	-$7,145,500
FEDERAL FUNDS	$0	-$7,145,500

DESCRIPTION

Purpose:
This policy change estimates the savings resulting from the imposition of a copayment for non-emergency use of the emergency room.

Authority:
Proposed Legislation
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, section 14134(c)(1)

Background:
AB 97 implemented a mandatory copayment of $50 for non-emergency use of the emergency room. The Department is proposing legislation to revise the copayment amount from $50 to $15.

Pending approval from the Centers for Medicare & Medicaid Services (CMS), this copayment will be implemented in the managed care setting and will not apply to those who are Family Planning, Access, Care and Treatment (FPACT) program beneficiaries. The hospital will collect the $15 copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the $15 copayment.

Reason for Change from Prior Estimate:
Due to a delay in receiving CMS approval, the implementation date is changed from October 1, 2012 to January 1, 2013.

Methodology:
1. It is assumed that the copayment will be implemented January 1, 2013.

2. The managed care savings are estimated to be $14,291,000 TF ($7,145,500 GF) in FY 2012-13.

FY 2012-13 Savings:	**TF**	**GF**
Managed Care	($14,291,000)	($7,145,500)

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 36

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

PHARMACY COPAYMENTS

REGULAR POLICY CHANGE NUMBER: 37
IMPLEMENTATION DATE: 1/2013
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1520

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	-$26,116,000
- STATE FUNDS	$0	-$13,058,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$26,116,000
STATE FUNDS	$0	-$13,058,000
FEDERAL FUNDS	$0	-$13,058,000

DESCRIPTION

Purpose:
This policy change estimates the savings related to mandatory copayments for prescription drugs.

Authority:
Proposed Legislation
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, section 14134(c)(4)

Background:
AB 97 requires mandatory copayments of $3 per prescription for preferred drugs and $5 per prescription for non-preferred drugs. The Department is proposing legislation to revise the copayment amount to $3.10 for non-preferred drugs only.

Pending approval from the Centers of Medicare and Medicaid Services (CMS), these copayments will be implemented in the managed care setting and will not apply to those who are Family Planning, Access, Care and Treatment (FPACT) beneficiaries. The pharmacy will collect the $3.10 copayment from the beneficiaries at the time of service, and the pharmacy will be reimbursed the appropriate Medi-Cal reimbursement rate minus the $3.10 copayment.

Reason for Change from Prior Estimate:
Due to a delay in receiving CMS approval, the implementation date is changed from October 1, 2012 to January 1, 2013.

Methodology:
1. It is assumed that the copayment will be implemented January 1, 2013.

2. The managed care savings are estimated to be $26,116,000 TF ($13,058,000 GF) in FY 2012-13.

FY 2012-13 Savings:	**TF**	**GF**
Managed Care	**($26,116,000)**	**($13,058,000)**

PHARMACY COPAYMENTS

REGULAR POLICY CHANGE NUMBER: 37

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

ELIMINATE ADHC SERVICES

REGULAR POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1472

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$355,915,000	-$361,802,000
- STATE FUNDS	-$177,957,500	-$180,901,000
PAYMENT LAG	0.8010	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$285,087,900	-$361,802,000
STATE FUNDS	-$142,543,960	-$180,901,000
FEDERAL FUNDS	-$142,543,960	-$180,901,000

DESCRIPTION

Purpose:
This policy change estimates the savings due to the elimination of Adult Day Health Care (ADHC) services from the Medi-Cal program.

Authority:
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, sections 14589-14590

Background:
ADHC is a community-based day program providing health, therapeutic, and social services designed to serve those at risk of institutionalization. The ADHC Program is funded via the Medi-Cal budget with State General Fund and Title XIX federal funds. The California Department of Public Health (CDPH) performs the licensing of Medi-Cal ADHCs. The Department of Aging (CDA) administers the program and certifies each center for Medi-Cal reimbursement.

AB 97 eliminates ADHC services as an optional benefit under the Medi-Cal program, effective July 1, 2011. A class action lawsuit, *Esther Darling, et. al. v. Toby Douglas, et. al.* sought to challenge the elimination of ADHC services. A settlement was reached that establishes a new program, Community-Based Adult Services (CBAS). See the ADHC Transition policy changes for the impact on ADHC/CBAS services under the settlement.

Reason for Change from Prior Estimate:
There is no material change.

Methodology:
1. Assume that savings will begin on July 1, 2011.

2. Expenditures for ADHC services are estimated to be $321,748,000 in FY 2011-12 and $327,635,000 in FY 2012-13 (see Adult Day Health Care – CDA policy change).

3. In addition, expenditures for ADHC services provided in an FQHC are estimated to be $34,167,000 annually for both FY 2011-12 and FY 2012-13.

ELIMINATE ADHC SERVICES

REGULAR POLICY CHANGE NUMBER: 40

4. Total ADHC expenditures are estimated to be:

   FY 2011-12: $321,748,000+ $34,167,000 = $355,915,000
   FY 2012-13: $327,635,000+ $34,167,000 = $361,802,000

5. ADHC savings are estimated to be:

   FY 2011-12 Savings: $355,915,000 TF ($177,957,500 GF)
   FY 2012-13 Savings: $361,802,000 TF ($180,901,000 GF)

6. The costs of delaying the elimination of ADHC services until April 1, 2012, are reflected in the ADHC Transition policy change.

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

FEDERAL DRUG REBATE CHANGE

REGULAR POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 10/2010
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1559

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$92,909,000	$108,000,000
- STATE FUNDS	$92,909,000	$108,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$92,909,000	$108,000,000
STATE FUNDS	$92,909,000	$108,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost related to the retroactive rebates and ongoing rebates that were not adjusted for the increase in the share of rebates the Centers for Medicare & Medicaid Services (CMS) collects.

Authority:
Affordable Care Act (ACA), H.R. 3590

Background:
The ACA, H.R. 3590, increased the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increased the multi-source drug rebate from 11% of AMP to 13%. CMS is claiming 100% of the 8% single source and 2% multi-source differential in the rebate increases. This will result in a cost to the Medi-Cal program, because California currently collects rebates at the higher percentage for most drugs and retains the General Fund (GF) share at the current Federal Medical Assistance Percentage (FMAP) rate, for all rebates collected.

The Department is required to pay back the GF share of the differential to CMS. CMS agreed to collect 25% of the amount owed for the first quarter, 50% of the amount owed for the next three quarters, and 100% thereafter until reconciliation for these time periods is completed. Once the reconciliation is completed, the Department will be required to pay any outstanding amount owed. The Department is required to complete the reconciliation process by September 30, 2012.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. CMS will send the Department an estimated quarterly rebate offset amount (EQROA) to be remitted to the federal government. The EQROA will be reconciled with the total quarterly rebate offset amount (QROA) when the Department receives the unit offset amount from CMS.

FEDERAL DRUG REBATE CHANGE

REGULAR POLICY CHANGE NUMBER: 41

2. In October 2010, CMS began collecting the additional federal financial participation (FFP) for the rebates collected by the Department retroactive to January 1, 2010.

3. The Department estimates that the rebate increase differential owed to CMS will be $76 million per quarter. Currently, the Department pays CMS back at the current FMAP of that total.

4. Assume that, beginning with the October 2011 payment, CMS will collect 100% of the estimated additional amount due.

5. In FY 2012-13, the Department will pay $38 million for the April 2012 payment and $70 million to CMS for the final reconciliation of prior payments that included a discount factor.

6. Once the final reconciliation process is completed by September 2012, the additional FFP that CMS collects for federal drug rebates will be fully reflected in the Federal Drug Rebate Program policy change.

FY 2011-12		
July 2011 payment	$33,818,000 x 50% =	$ 16,909,000
October 2011 payment	$38,000,000 x 100% =	$ 38,000,000
January 2012 payment	$38,000,000 x 100% =	$ 38,000,000
		$ 92,909,000

FY 2012-13		
April 2012 payment	$38,000,000 x 100% =	$ 38,000,000
Reconciliation payment		$ 70,000,000
		$108,000,000

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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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 pharmacy drug payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

Funding:
Title XIX 100% GF (4260-101-0001)

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 3/2007
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 108

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$2,118,000	$1,488,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$2,118,000	$1,488,000
FEDERAL FUNDS	-$2,118,000	-$1,488,000

DESCRIPTION

Purpose:
This policy change budgets 100% GF costs to reimburse the federal share to the Centers for Medicare and Medicaid Services (CMS) for drugs ineligible for federal financial participation (Non-FFP drugs).

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

Background:
Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid programs if the manufacturer of the drug has not signed a rebate contract with the CMS.

Effective March 2007, an automated quarterly report was made available to determine the costs of drugs for which there is no FFP. The Department reimburses the federal government for FFP claimed for these drugs.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data.

Methodology:
1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased.

2. 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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 42

3. 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 pharmacy drug payments, when Medi-Cal draws the federal funds in a subsequent fiscal year.

(In Thousands)

Fiscal Year	Non-FFP Drug Exp.	Est. FFP Repayment	50%FFP	ARRA
FY 2011-12	$3,904	**$2,118**	$1,952	$166
FY 2012-13	$2,976	**$1,488**	$0	$0

Funding:
Title XIX 100% GF (4260-101-0001)

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 1/2010
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1433

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$14,000,000	-$14,000,000
- STATE FUNDS	-$4,900,000	-$4,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$14,000,000	-$14,000,000
STATE FUNDS	-$4,900,000	-$4,900,000
FEDERAL FUNDS	-$9,100,000	-$9,100,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Welfare and Institutions Code, section 14105.33(b)(4)

Background:
Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP program in January 2010. This policy change reflects ongoing rebates invoiced. Revenues resulting from the resolution of disputed rebates are budgeted in the Aged and Disputed Drug Rebate policy change.

Reason for Change from Prior Estimate:
Projections were revised based on an upward trend in actual data.

Methodology:
1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The ongoing rebates collected are estimated to be $14,000,000 annually.

   FY 2011-12: $14,000,000 TF ($4,900,000 GF)

   FY 2012-13: $14,000,000 TF ($4,900,000 GF)

Funding:
Title XIX 65/35 FFP (4260-101-0001/0890)

PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	4/2012
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1434

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$33,250,000	-$57,000,000
- STATE FUNDS	-$16,625,000	-$28,500,000
PAYMENT LAG	0.7790	0.9950
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$25,901,800	-$56,715,000
STATE FUNDS	-$12,950,880	-$28,357,500
FEDERAL FUNDS	-$12,950,880	-$28,357,500

DESCRIPTION

Purpose:
This policy change estimates the savings related to the change in the reimbursement rate methodology for physician-administered drugs.

Authority:
SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code, section 14105.456

Background:
The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. SB 853 established a new reimbursement rate methodology for physician-administered drugs to be reimbursed consistent with Medi-Cal rates of payment for non-physician-administered pharmaceuticals beginning in January 2011. The new methodology is expected to generate savings beginning April 2012 for claims from September 2011 and ongoing pending Centers for Medicare and Medicaid Services (CMS) approval of the State Plan Amendment (SPA).

The Department is conducting a study of the acquisition costs for drugs purchased by non-pharmacy providers prior to implementation of this reimbursement change, as well as the staffing needed to implement the rate adjustment, which is budgeted in the Rate Study for Physician-Administered Drugs policy change.

Reason for Change from Prior Estimate:
The estimated savings have changed due to the findings from a rate study conducted by Myers and Stauffers of the reimbursement methodology.

Methodology:
1. Assume CMS will approve the SPA and the savings will begin in April 2012.

2. Assume implementation will be retroactive to September 2011.

3. Annual savings are estimated to be $57,000,000 TF ($28,500,000 GF).

PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 44

4. Assume the claims from September 2011 through March 2012 will be collected in FY 2011-12 and claims from April 2012 through June 2012 will be collected in FY 2012-13.

5. Savings are estimated to be:

   FY 2011-12: $57,000,000 ÷ 12 mos. x 7 mos. = **$33,250,000 TF ($16,625,000 GF)**

   FY 2012-13: $57,000,000 TF ($28,500,000 GF)

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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 10/2006
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1181

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$30,236,000	-$24,900,000
- STATE FUNDS	-$15,118,000	-$12,450,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$30,236,000	-$24,900,000
STATE FUNDS	-$15,118,000	-$12,450,000
FEDERAL FUNDS	-$15,118,000	-$12,450,000

DESCRIPTION

Purpose:
This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Authority:
Welfare and Institutions Code, sections 14100.95(a) and 14105.47(c)(1)

Background:
A contracted Maximum Acquisition Cost (MAC) for medical supply diabetic products has resulted in savings to the Department. The product reimbursement rates for diabetic testing products are based on the contracted MAC.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers.

Reason for Change from Prior Estimate:
The estimated FY 2011-12 savings has decreased based on the shift in Seniors and Persons with Disabilities (SPD) population from fee-for-service (FFS) to managed care.

The estimated FY 2012-13 savings reflects a decrease from an anticipated drop in rebate percentages based on the renegotiated contract.

Methodology:
1. Based on rebates received for July 2011 to March 2012, the Department assumes a collection of $30,236,000 in FY 2011-12.

2. Assume the current medical supply diabetic testing products contract will be renegotiated and the new contract will be effective January 1, 2013.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 45

3. Based on the renegotiation of the new contract, assume expenditures will decrease, resulting in lower rebates received in the third and fourth quarters of FY 2012-13.

   $7,114,000 x 2 qtrs. = $14,228,000 + $5,336,000 x 2 qtrs. = $10,672,000

CASH BASIS	Medical Supply Rebates
FY 2009-10	$ 11,256,000
FY 2010-11	$ 33,314,000
Est. FY 2011-12	**$ 30,236,000**
Est. FY 2012-13	**$ 24,900,000**

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

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	4/2004
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1182

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$134,740,000	-$55,000,000
- STATE FUNDS	-$67,198,000	-$27,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$134,740,000	-$55,000,000
STATE FUNDS	-$67,198,000	-$27,430,000
FEDERAL FUNDS	-$67,542,000	-$27,570,000

DESCRIPTION

Purpose:
This policy change estimates the recovery of monies due to the resolution of aged and disputed drug rebate payments for the State Supplemental Rebate Program, the Federal Rebate Program, the Breast and Cervical Cancer Treatment Program (BCCTP) and the Family Planning, Access, Care and Treatment (FPACT) program.

Authority:
Welfare and Institutions Code, Section 14105.33

Background:
Aged Rebates
Between 1991 and 2002, the Medi-Cal program accumulated large rebate disputes with participating drug companies for which the Department was cited in an audit of the rebate program by the Office of Inspector General (OIG). The Legislature approved funding in the Budget Act of 2003 for the Department to add additional staff to resolve aged drug rebate payment disputes.

The Department has completed its work on the oldest aged rebate disputes (1991-96) and is awaiting final agreements from a few pharmaceutical companies, which account for a majority of the disputes, before closing out the time period. The Department has begun work on disputes for the 1997-2002 time period.

Disputed Rebates
Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are being defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and receive payments.

	Federal & State Rebates
FY 2011-12	($134,740,000)
FY 2012-13	($ 55,000,000)

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 46

Reason for Change from Prior Estimate:
The estimated savings increased based on the Department's resolution of older and substantial rebate disputes.

Methodology:
Not applicable.

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	12/1999
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	51

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$70,826,000	-$70,417,000
- STATE FUNDS	-$9,267,000	-$9,213,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$70,826,000	-$70,417,000
STATE FUNDS	-$9,267,000	-$9,213,300
FEDERAL FUNDS	-$61,559,000	-$61,203,700

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Welfare and Institutions Code, section 14105.33 (b)(4)

Background:
Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data.

Methodology:
1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.71% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 92.29% of the FPACT rebates.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 47

CASH BASIS
(In Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2010-11	$161,819	($68,566)
Est. FY 2011-12		**($70,826)**
Est. FY 2012-13		**($70,417)**

	TF	50% FFP	90% FFP
FY 2011-12	**($70,826)**	($5,461)	($65,365)
FY 2012-13	**($70,417)**	($5,429)	($64,988)

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 8/2009
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1449

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$115,368,000	$0
- STATE FUNDS	-$115,368,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$115,368,000	$0
STATE FUNDS	-$115,368,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to the overcharges related to provider fraud against the Medi-Cal program.

Authority:
Not applicable

Background:
The Department works collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks and overcharging Medicaid.

Reason for Change from Prior Estimate:
Additional settlement agreements.

Methodology:
The following settlements are expected to be received in FY 2011-12:

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 48

	FY 2011-12 Settlement Payments
CVS	$ 879,000
Eisai/Elan	$ 2,319,000
LabCorp	$ 10,281,000
Mariner/SavaSeniorCare	$ 1,229,000
Maxim	$ 7,325,000
Merck	$ 19,124,000
Novartis	$ 810,000
Novo Nordisk	$ 440,000
Pfizer	$ 309,000
Quest Diagnostics	$ 50,055,000
Seacliff Diagnostics	$ 124,000
Serono	$ 635,000
UCB, Inc.	$ 450,000
Ven-A-Care of the Florida Keys (Sandoz)	$ 21,308,000
Whitefield Medical Lab	$ 80,000
Total GF Savings	**$ 115,368,000**

Funding:
Title XIX 100% GF (4260-101-0001)

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 9/2012
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1585

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	-$316,347,000
- STATE FUNDS	$0	-$158,173,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$316,347,000
STATE FUNDS	$0	-$158,173,500
FEDERAL FUNDS	$0	-$158,173,500

DESCRIPTION

Purpose:
This policy change estimates the amount of monies received from the collection of additional Managed Care drug rebates.

Authority:
Social Security Act Section 1927(b) as amended by Section 2501(c) of Patient Protection and Affordable Care Act (PPACA).

Background:
The PPACA, H.R. 3590, and the Health Care and Education Reconciliation Act of 2010 (HCERA), extend the federal drug rebate requirement to Medicaid managed care outpatient covered drugs provided by the Geographic Managed Care (GMC) and Two-Plan model plans, and the Health Plan of San Mateo (HPSM), a County Organized Health System (COHS). Previously, only COHS plans, with the exception of HPSM, were subject to the rebate requirement.

Reason for Change from Prior Estimate:
California Medicaid Management Information System (CA-MISS) system updates were not implemented in 2011-12; as a result, invoicing for managed care drugs did not commence.

The new collection projections are based on updated historical data provided by the Capitated Rates Development Division, as well as the shift in Seniors and Persons with Disabilities (SPD) population from fee-for-service (FFS) to managed care.

Methodology:
1. Rebates are invoiced quarterly.

2. Assume invoicing will begin in August 2012, retroactive to March 23, 2010.

3. Assume rebates will be received beginning in September 2012.

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49

4. Assume the Department will collect $509 million TF in retroactive rebates and $70 million TF ongoing for each quarter.

5. Assume the collection of all managed care rebates (retroactive and current) will not be collected immediately due to disputes from drug manufacturers.

6. Assume the Department will collect 40% of the retroactive and current amounts invoiced in FY 2012-13.

7. The Department estimates $316,347,000 TF ($158,173,500 GF) will be collected in FY 2012-13.

FY 2012-13	
Retroactive Rebates	$ 203,961,000
FY 2012-13	$ 112,386,000
Total	**$ 316,347,000**

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

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	1/1991
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	54

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$113,796,000	-$95,942,000
- STATE FUNDS	-$52,005,800	-$47,848,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$113,796,000	-$95,942,000
STATE FUNDS	-$52,005,800	-$47,848,600
FEDERAL FUNDS	-$61,790,200	-$48,093,400

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare and Institutions Code, section 14105.33

Background:
State supplemental drug rebates for drugs provided through fee-for-service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data.

Methodology:
1. Family planning drugs are 0.319% of rebates and are funded with 90% federal funds and 10% General Fund.

2. In October 2009, the Centers for Medicare & Medicaid Services (CMS) released Federal Upper Limits (FULs) for some products, which have created lower net cost for some generically available products. As a result of lower utilization of the equivalent brand name products, drug rebates are expected to decrease in FY 2011-12 and FY 2012-13.

3. 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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 50

4. 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 pharmacy drug payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

CASH BASIS
(In Thousands)

Fiscal Year	FFS Trends	Supplemental Rebate Savings
FY 2010-11	$3,338,653	($ 172,705)
Est. FY 2011-12		**($ 104,302)**
Est. FY 2012-13		**($ 95,942)**

	TF	50% FFP	90% FFP	ARRA
FY 2011-12	**($104,302)**	($51,969)	($363)	($9,494)
FY 2012-13	**($95,942)**	($47,818)	($306)	

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	7/1990
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	55

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$1,331,040,000	-$1,100,415,000
- STATE FUNDS	-$628,032,600	-$548,803,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,331,040,000	-$1,100,415,000
STATE FUNDS	-$628,032,600	-$548,803,500
FEDERAL FUNDS	-$703,007,400	-$551,611,500

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.

Background:
The State Medi-Cal Drug Discount Program and OBRA 1990 allows the Department to obtain price discounts for drugs. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data.

Methodology:
1. Family planning drugs are 0.319% of rebates and are funded with 90% federal funds and 10% General Fund.

2. Beginning September 2012, the Federal Drug Rebate Change policy change which reflects the higher federal funding participation (FFP) claimed by the Centers for Medicare and Medicaid Services (CMS) will be fully reflected in this policy change.

3. 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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

4. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 51

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 pharmacy drug payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

CASH BASIS
(In Thousands)

Fiscal Year	FFS Trends	Federal Rebate Savings
FY 2010-11	$3,338,653	($1,302,009)
Est. FY 2011-12		**($1,259,461)**
Est. FY 2012-13		**($1,100,415)**

	TF	50% FFP	90% FFP	ARRA
FY 2011-12	**($1,259,461)**	($627,608)	($4,821)	($71,578)
FY 2012-13	**($1,100,415)**	($548,453)	($3,159)	

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1054

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$229,051,000	$525,946,000
- STATE FUNDS	$87,626,000	$234,345,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$229,051,000	$525,946,000
STATE FUNDS	$87,626,000	$234,345,000
FEDERAL FUNDS	$141,425,000	$291,601,000

DESCRIPTION

Purpose
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties to the Department for the purpose of providing capitation rate increases to the managed care plans.

Authority:
Welfare & Institutions Code, sections 14163 and 14164

Background:
An IGT is a transfer of funds from a public entity to the State. The non-federal share from the fund is matched with federal funds and used to make payments for capitation rate increases.

The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Reason for Change from Prior Estimate:
The policy change was revised to incorporate updated IGTs.

Methodology:
COHS:
The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010. The IGT will continue on an ongoing basis.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; and Merced and Sonoma Counties were effective retroactive to October 1, 2009. The IGTs will continue on an ongoing basis.

The IGTs for Orange, Napa, and Yolo Counties are expected to be effective retroactive to July 1, 2010; and Marin County is expected to be effective July 1, 2011. Once approved by Centers for Medicare and Medicaid Services (CMS), it is anticipated the IGTs will continue on an ongoing basis.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 55

Two Plan Model:
An IGT for Los Angeles County was effective October 2006 and will continue on an ongoing basis.

IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara Counties were effective retroactive to October 1, 2008, and they will continue on an ongoing basis.

AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax (MCO 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 of the Gross Premium Tax on Medi-Cal managed care plans. For additional information see policy change Extend Gross Premium Tax –Incr. Capitation Rates and Extend Gross Premium Tax-Funding Adjustment. 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.

(In Thousands)

FY 2011-12

	IGT*	Regular FFP	ARRA FFP	T21 FFP	Total FFP	TF
Total	**$87,626**	**$109,356**	**$25,348**	**$6,721**	**$141,425**	**$229,051**

FY 2012-13

	IGT*	Regular FFP	ARRA FFP	T21 FFP	Total FFP	TF
Total	**$234,345**	**$250,230**	**$23,397**	**$17,974**	**$291,601**	**$525,946**

Funding:
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)
Reimbursement (4260-610-0995)*

INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 11/2009
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1455

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$265,213,000	$20,704,000
- STATE FUNDS	$133,527,000	$10,424,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$265,213,000	$20,704,000
STATE FUNDS	$133,527,000	$10,424,000
FEDERAL FUNDS	$131,686,000	$10,280,000

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by the gross premium tax proceeds. These funds will be used for the non-federal share of capitation rate increases.

Authority:
AB 1422 (Chapter 157, Statutes of 2009)
ABX1 21 (Chapter 11, Statutes of 2009)

Background:
AB 1422 imposed a Gross Premium Tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

Reason for Change from Previous Estimate:
The most recent estimates of managed care revenues have been used to estimate the gross premium tax amount.

Methodology:
1. The gross premium tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the gross premium tax.

2. The provision pertaining to the gross premium tax was effective retroactively to January 1, 2009 through June 30, 2011.

3. ABX1 21 extended the gross premium tax through June 30, 2012. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period will be matched with federal funds at the level in effect at that time.

INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 56

4. Capitation rate increases due to the gross premium tax are initially paid from the General Fund (GF). The GF 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 Gross Premium Tax to GF policy change.

5. While most of Medi-Cal's expenditures receive the applicable Federal Medicaid Assistance Percentage (FMAP) in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased American Recovery and Reinvestment Act of 2009 (ARRA) FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as Gross Premium Tax, and Medi-Cal draws the federal funds in a subsequent fiscal year.

6. FY 2012-13 amounts are one-time retroactive rate adjustments using FY 2011-12 Gross Premium Taxes.

(In Thousands)	Gross Premium Tax	FFP	TF
Total FY 2011-12	$133,527	$131,686	**$265,213**
Total FY 2012-13	$10,352	$10,352	**$20,704**

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

MANAGED CARE COST BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 10/2011
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1618

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$29,743,000	$90,073,000
- STATE FUNDS	-$14,871,500	$45,036,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$29,743,000	$90,073,000
STATE FUNDS	-$14,871,500	$45,036,500
FEDERAL FUNDS	-$14,871,500	$45,036,500

DESCRIPTION

Purpose:
The policy change estimates the funding adjustment for cost based reimbursement clinics (CBRC) transitioning from fee-for-service (FFS) into the managed care program exclusively for the seniors and persons with disabilities (SPD) population residing in the Los Angeles County.

Authority:
Welfare & Institutions Code, section 14105.24 (a)

Background:
The Department will reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. For periods prior to the SPD transition, a tentative settlement is prepared by the Department after review of the reconciliation request. Within three years after the date of submission of the original reconciliation report, as required, a final audit is performed and either a final settlement or recovery invoice is prepared. The Department will transition these costs to managed care, thereby, eliminating the reconciliation process. As a result, the transition of these costs to the managed care program is a funding shift only and will result in an equivalent savings to the FFS program.

Previously, an interim rate was paid to the clinics and is adjusted once the audit reports were finalized. That rate was used for subsequent fiscal year claims. The Department is scheduled to complete the audits for 2007-08 in 2011-12 and for 2008-09 in 2012-13. Interim rates will be adjusted to the FY 2006-07 audited levels beginning in FY 2011-12, and to the FY 2007-08 audited levels in FY 2012-13. These reconciliations are budgeted in the FQHC/RHC/CBRC Reconciliation Process policy change. Managed care costs for FY 2011-12 are expected to be paid in FY 2012-13.

Reason for Change from Prior Estimate:
Adjustments were made to accommodate for the CBRCs rates that will not be received and approved until FY 12-13. Payments will not be made until CMS approval is received. FY 11-12 costs have been moved to FY 12-13.

MANAGED CARE COST BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 60

Methodology:

1. Assume costs will be retroactive to October 1, 2011.

2. Assume the managed care costs are the actuarial equivalent of the FFS costs.

3. Based on FY 2010-11 annual costs of $91,063,000, assume there will be an annual growth of 5.71% based on historical data.

4. Annualized managed care costs are $96,263,000 for FY 2011-12.

5. Because of the 12-month June 2011 to May 2012 phase-in of SPDs into managed care, the managed care costs will be $53,479,000 in FY 2011-12 and are expected to be paid in FY 2012-13.

6. Total managed care costs will be $155,239,000 for FY 2012-13 which include the FY 2011-12 managed care costs in the amount of $53,479,000 and $101,760,000 for FY 2012-13.

7. While the transition of these costs from FFS to managed care is effective October 1, 2011, the adjustment to the managed care plan payments will not begin until FY 2012-13 when CMS approval is anticipated.

8. Cost settlements that would have occurred in future years for these SPDs will no longer have to be made because they will be included in the managed care capitation rates. For FY 2011-12, these settlements are estimated to be $19,232,000 and would have been made in FY 2014-15. For FY 2012-13, these settlements are estimated to be $36,593,000 would have been made in FY 2015-16.

9. FFS savings will be $29,743,000 for FY 2011-12 and $65,166,000 for FY 2012-13.

10. The FFS costs are in the base estimate. There will be a savings to the base estimate as a result of shifting the costs from the FFS base into managed care for the SPDs.

	FY 2011-12	FY 2012-13
Managed Care Costs	$0	$155,239,000
FFS Savings	-$29,743,000	-$65,166,000
Total Costs	**-$29,743,000**	**$90,073,000**

Funding:

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

COURT-ORDERED MANAGED CARE RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 7/2009
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1361

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$32,400,000	$0
- STATE FUNDS	$16,200,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$32,400,000	$0
STATE FUNDS	$16,200,000	$0
FEDERAL FUNDS	$16,200,000	$0

DESCRIPTION

Purpose:
The policy change estimates the costs for the prejudgment interest in the case *Health Net of California v. Department of Health Services*.

Authority:
The Third District Court of Appeals ruled the Department must pay prejudgment interest in February 2012.

Background:
The Third District Court of Appeal ruled that the Department must pay $27.4 million as well as prejudgment interest, post-judgment interest, and costs to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002. In FY 2009-10, $14.6 million was paid to Health Net. An additional payment of $2.99 million was paid in FY 2010-11. The Department anticipates paying the remaining balance of $32.4 million in April 2012.

	FY 2011-12
Total Cost	**$32,400,000**

Reason for Change from Prior Estimate:
Updated payment calculation.

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

NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 7/1998
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 95

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$2,000,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,000,000	$2,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change includes funds for settlement agreements for disputes between the Department and managed care plans.

Authority:
Not applicable

Background:
Various managed care plans have filed grievances or appeals challenging the rates the Department has established for the managed care programs. Every six months the Department develops an estimate of likely settlements for these disputes.

The Department attempts to claim federal funding, however, this policy change adjusts for settlements that are beyond the federal claiming deadline or include payments outside of the actuarially sound rate ranges. These settlements are budgeted at 100% General Fund.

Reason for Change from Prior Estimate:
There is no change.

Funding:
100% General Fund (4260-101-0001)

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1588

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$900,000,000
- STATE FUNDS	$0	$450,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$900,000,000
STATE FUNDS	$0	$450,000,000
FEDERAL FUNDS	$0	$450,000,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases.

Authority:
Senate Bill 208 (Chapter 714, Statutes of 2010)

Background:
Effective June 1, 2011, Medi-Cal managed care began assigning Seniors and Persons with Disabilities (SPDs) as mandatory enrollees in managed care health plans in both Two-Plan and Geographic Managed Care model counties per SB 208. In implementing the mandatory enrollment of SPDs, SB 208 allows DPHs, on a voluntary basis, to provide the State an IGT to be used as the non-federal share of capitation rate increases that will enable Medi-Cal managed care plans to compensate DPHs in amounts that are no less than what they would have received for providing services to these beneficiaries under the Fee-For-Service (FFS) model, including supplemental payments and any additional federally permissible amounts, which are available only under FFS. The purpose of these IGTs is to enable managed care plans to compensate DPHs in a sufficient amount so as to preserve and strengthen the availability and quality of services provided by these DPHs. It is also the intent that transferring public entities elect to provide IGTs in an amount that is at least equivalent to the amount of the nonfederal share that they would have provided under FFS, as adjusted for utilization.

On an annual basis, it is anticipated this will result in IGTs of $277 million and $554 million in increased capitation rates. Because the SPD enrollment transition will occur over a period of time beginning June 1, 2011, the initial IGT is estimated to be $173 million for the period June 1, 2011 through June 30, 2012, which is assumed to be transferred in FY 2012-13 after CMS approval.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 65

(In Thousands)	IGT	FFP	TF
FY 2012-13			
FY 2011-12	$173,000	$173,000	$346,000
FY 2012-13	$277,000	$277,000	$554,000
Total	**$450,000**	**$450,000**	**$900,000**

Reason for Change from Prior Estimate:
There is no change.

Methodology:
Not applicable.

Funding:
Title XIX 100% FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 1/2013
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1482

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	-$743,000
- STATE FUNDS	$0	-$371,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$743,000
STATE FUNDS	$0	-$371,500
FEDERAL FUNDS	$0	-$371,500

DESCRIPTION

Purpose:
This policy change estimates the costs due to moving undocumented beneficiaries from Partnership Health Plan of California (PHC), a Managed Care plan, into FFS.

Authority:
Contract # 08-85215

Background:
PHC's Medi-Cal managed care contract covered undocumented beneficiaries in Solano, Napa and Yolo Counties. Managed Care contracts with other health plans do not include undocumented beneficiaries. To ensure all managed care model plans are consistent, PHC is negotiating with the Department to remove the undocumented beneficiaries from their contract. The implementation date of this shift will occur on January 1, 2013.

Reason for Change from Prior Estimate:
Changes occurred due to the updated rates and member months.

Methodology:
1. It is assumed the annual member months for undocumented beneficiaries will be 3,769 for Solano County, 1,803 for Napa County, and 1,968 for Yolo County.

2. The FY 2012-13 undocumented beneficiary rates are assumed to be $351.19 for Solano County, $529.67 for Napa County, and $550.83 for Yolo County.

3. The FY 2012-13 cost, for period January 1, 2013 through June 30, 2013, for undocumented beneficiaries by county is expected to be:

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 67

Solano County: 3,769 x $351.19 / 12 months x 6 months = $662,000
Napa County: 1,803 x $529.67 / 12 months x 6 months = $477,000
Yolo County: 1,968 x $550.83 / 12 months x 6 months = $542,000

$662,000 + $477,000 + $542,000 = $1,681,000

4. The shift of undocumented beneficiaries to FFS is expected to have the following impact:

$1,681,000	FFS cost
-$1,681,000	Managed Care savings
$0	Net annual impact of shift to FFS

5. There will be a net savings in FY 2012-13 due to the capitation payments ending on December 30, 2012. The savings is budgeted in the County Organized Health Systems (COHS) policy change, therefore, the lagged FFS costs is budgeted in this policy change. There will be a lag in FFS payments due to the time it take for providers to bill and be paid for services.

	FY 2012-13
Managed Care Savings	-$1,681,000
FFS Cost	$1,681,000
FFS Payment Lag	0.558
Lagged FFS Costs	$938,000
Net costs (Rounded)	**-$743,000**

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

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 2/2011
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1586

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates for the transfer of funds from the Gross Premium Tax Fund to the General Fund.

Authority:
AB 1422 (Chapter 157, Statutes of 2009)
ABX1 21 (Chapter 11, Statutes of 2011)

Background:
AB 1422 imposed a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans. The proceeds from the tax are 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 Gross Premium 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.

Reason for Change from Prior Estimate:
The most recent estimates of gross premium tax revenues have been used to estimate the funding adjustment.

Methodology:
1. Funding adjustments for FY 2010-11 of $57.8 million and $9.0 were made in July 2011 and October 2011, respectively.

2. Annually, the plans are required to file a tax return (reconciliation) by April 1 for the previous calendar year.

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 68

3. Calendar year 2011 payment reconciliation will be paid by April 1, 2012.

4. Calendar year 2012 payment reconciliation will be paid by April 1, 2013.

	FY 2011-12
January 2011 - June 2011	$57,800,000
July 2011 - September 2011	$8,956,000
October 2011 – December 2011	$40,400,000
January 2012 - March 2012	$30,167,000
CY 2011 Reconciliation	$26,579,000
Total Gross Premium Tax	**$163,902,000**
GF	**-$163,902,000**
Total	**$0**

	FY 2012-13
Total Gross Premium Tax	**$42,657,000**
GF	**-$42,657,000**
Total	**$0**

Funding:
100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 7/2005
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1082

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change is for informational purposes only.

Authority:
Not applicable.

Background:
This policy change specifies the cost of services that are in addition to the managed care capitation rates. FFS expenditures occur for managed care enrollees for covered Medi-Cal services excluded by the health plan contract.

In Fiscal Year 2010-2011 FFS payments for managed care enrollees totaled:

Expenditures by Aid Category

	Other	CCS/GHPP	Total
Families	$399,883,000	$522,215,000	$922,098,000
Disabled	$285,434,000	$368,769,000	$654,203,000
Aged	$65,118,000	$45,000	$65,163,000
200% Poverty	$7,657,000	$34,246,000	$41,903,000
MI Child	$7,073,000	$23,336,000	$30,409,000
133% Poverty	$7,956,000	$9,013,000	$16,969,000
Other	$1,717,000	$6,000	$1,723,000
100% Poverty	$7,379,000	$21,949,000	$29,328,000
Blind	$3,257,000	$6,006,000	$9,263,000
MI Adult	$3,466,000	$156,000	$3,622,000
Totals	**$788,940,000**	**$985,741,000**	**$1,774,681,000**

Reason for Change from Prior Estimate:
There is no change.

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 69

Funding:
Not applicable.

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1601

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose
This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities.

Authority:
AB 102 (Chapter 29, Statutes of 2011) provides that all IGTs used to fund increases through the rate range are subject to the fee with the exception of the certain IGTs related to designated public hospitals and IGTs authorized pursuant to Welfare & Institutions Code Sections 14168.7 and 14182.15.

Background:
The counties/public entities transfer funds as IGTs to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds are used for the nonfederal share of capitation rate increases which are budgeted in the Managed Care Rate Range IGT policy change. The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Beginning July 1, 2011, the Department will charge counties/public entities an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the support of the Medi-Cal program as well as state support costs. FY 2012-13 savings includes all entities participating in an IGT other than the FY 2010-11 San Mateo IGT.

Reason for Change from Prior Period:
Admin fees are only assessed on IGTs in FY 2010-11 and forward and only FY 2009-10 IGTs were paid in FY 2011-12. The amounts for FY 2012-13 are revised based on updated IGTs.

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 70

Methodology:

1. The fee will be 20% of each IGT.

2. The state support costs are budgeted under state support.

(In Thousands)	IGT	20% Admin. & Processing Fee	Support Cost Reimbursement to GF	Local Assistance Reimbursement to GF
FY 2011-12	$ 0	$ 0	$ 0	**$ 0**
FY 2012-13	$ 234,345	$ 45,866	$ 251	**$ 45,615**

Funding:

Reimbursement (4260-610-0995)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1605

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to the General Fund (GF) by the Designated Public Hospitals (DPHs) for the costs that are built into the managed care capitation rates.

Authority:
Senate Bill 208 (Chapter 714, Statutes of 2010)

Background:
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care model counties. For Medi-Cal beneficiaries under the Fee For Service (FFS) program, payments to DPHs are comprised of Certified Public Expenditures matched with federal funds. For those under managed care, payments to DPHs are comprised of GF and federal funds. Therefore, as SPDs are transitioned into managed care, GF expenditures will increase for DPH services.

Beginning in FY 2012-13, DPHs will reimburse the GF for costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. Assume the intergovernmental transfer will be phased-in consistent with the enrollment of SPDs into managed care beginning June 1, 2011.

2. Assume the initial General Fund repayment for the period June 1, 2011 through June 30, 2012, will be $93,959,000 and will be made in FY 2012-13.

3. Beginning in FY 2012-13, $150,335,000 will be repaid annually to the General Fund.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 71

	FY 2012-13
June 2011 - June 2012 reimbursement from DPHs	$ 93,959,000
FY 2012-13 Reimbursement from DPHs	$ 150,335,000
Total Reimbursement	$ 244,294,000
GF	-$ 244,294,000
Net Impact	**$ 0**

Funding:
Reimbursement (4260-610-0995)

COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/2007
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1199

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$6,531,000	$2,682,000
- STATE FUNDS	-$3,265,500	$1,341,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,531,000	$2,682,000
STATE FUNDS	-$3,265,500	$1,341,000
FEDERAL FUNDS	-$3,265,500	$1,341,000

DESCRIPTION

Purpose:
This policy change estimates the cost of negotiated rates less the capitated rates and supplemental payment reconciliations for transitioning Agnews Developmental Center clients to the community.

Authority:
Welfare & Institutions (W&I) Code Sections 4500 et seq. (Lanterman Act), W&I Code commencing with 4474.5

Background:
Effective April 1, 2009, Agnews closed and a total of 300 Agnews clients have been moved into communities in Alameda, San Mateo, and Santa Clara counties. Of these, 214 are currently enrolled in managed care plans.

Due to the significant behavioral, health, and personal care needs of these clients, previous capitation rates did not provide sufficient funding to meet Agnews clients' needs. Prior to the negotiated rates the Department requested payment for the difference between the capitation payments and the supplemental payments followed by periodic reconciliations. As of December 2010, the Santa Clara Family Health Plan and July 1, 2008 for the Health Plan San Mateo have implemented full-risk capitation rates with the Department. New full risk capitation rates are effective retroactively to January 1, 2008. The Alameda Alliance Health Plan contract was amended in September 2011 with new full risk capitation rates retroactive to January 1, 2008.

Reason for Change from Prior Estimate:
Updated rates and eligibles.

COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER: 72

Methodology:

1. Assume the Managed Care model plans, Two Plan and COHS, Agnews rates for FY 2011-12 and FY 2012-13 are:

	Medi-Cal Only	Dual
Alameda Alliance	$3,136.42	$999.39
Santa Clara Family Health Plan	$3,209.78	$1,211.91
Health Plan of San Mateo	$3,353.49	$1,011.98

2. The plans are paid their initial capitation rate for FY 2011-12 based on the Dual and Medi-Cal only Disability:

	Medi-Cal Only	Dual
Alameda Alliance	$476.11	$476.11
Santa Clara Family Health Plan	$401.59	$401.59
Health Plan of San Mateo	$759.64	$759.64

FY 2012-13 initial capitation rates:

	Medi-Cal Only	Dual
Alameda Alliance	$492.96	$492.96
Santa Clara Family Health Plan	$398.31	$398.31
Health Plan of San Mateo	$787.06	$787.06

3. The net amount of the Agnews rate less the disabled rate for FY 2011-12 for Two Plan and COHS are:

	Medi-Cal Only	Dual
Alameda Alliance	$2,660.31	$523.28
Santa Clara Family Health Plan	$2,808.19	$813.60
Health Plan of San Mateo	$2,593.85	$252.34

The net amount of the Agnes rate less the disabled rate for FY 2012-13 for Two Plan and COHS are:

	Medi-Cal Only	Dual
Alameda Alliance	$2,643.46	$506.43
Santa Clara Family Health Plan	$2,811.47	$813.60
Health Plan of San Mateo	$2,566.43	$224.92

4. The total estimated reconciliation amount was $9,228,766. To date, the department has recovered $7,803,182 from the health plans and the remaining $1,425,584 will be recovered by the Department in FY 2011-12 for the reconciliation of the retroactive period. This amount is included in the amount budgeted for FY 2011-12.

Funding:

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

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	7/2008
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1329

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$177,502,000	$201,028,000
- STATE FUNDS	$88,751,000	$100,514,000
PAYMENT LAG	0.9901	0.9935
% REFLECTED IN BASE	4.97 %	4.90 %
APPLIED TO BASE		
TOTAL FUNDS	$167,010,200	$189,935,000
STATE FUNDS	$83,505,110	$94,967,490
FEDERAL FUNDS	$83,505,110	$94,967,490

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) according to the Prospective Payment System (PPS). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (CBRC) after a reconciliation audit has been completed.

Authority:
Welfare and Institutions Code, section 14170

Background:
For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, an interim rate is established and paid to the clinics. Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, managed care plans, and Medicare) in order to prepare a final settlement with the clinic.

Los Angeles County owned or operated CBRCs are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The 2006-07 audited levels were used to update the CBRC rates as of July 1, 2011. The Department is scheduled to complete the CBRC reconciliation audit for 2007-08 in 2011-12 and for 2008-09 in 2012-13. Interim rates will be adjusted to the FY 2007-08 audited levels beginning in FY 2011-12, and to the FY 2008-09 audited levels in FY 2012-13. Currently, there are 693 active FQHCs, 287 active RHCs and 29 active CBRCs.

Reason for Change from Prior Estimate:
The estimate was updated based on revised audits.