

**MEDI-CAL  
MAY 2013  
LOCAL ASSISTANCE ESTIMATE  
for  
FISCAL YEARS  
2012-13 and 2013-14**

**BASE POLICY  
CHANGES**

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**EDMUND G. BROWN JR.**  
Governor  
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Diana Dooley  
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Director  
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### **Medi-Cal Base Policy Changes**

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

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

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

#### **Base Policy Change Service Categories:**

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

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b><u>DRUG MEDI-CAL</u></b>				
53	NARCOTIC TREATMENT PROGRAM	\$60,389,000	\$60,389,000	\$0
54	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$23,640,000	\$23,640,000	\$0
55	DAY CARE REHABILITATIVE SERVICES	\$11,457,000	\$11,457,000	\$0
56	PERINATAL RESIDENTIAL SUBSTANCE USE DISORDI	\$859,000	\$859,000	\$0
57	NALTREXONE TREATMENT SERVICES	\$0	\$0	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$96,345,000</b>	<b>\$96,345,000</b>	<b>\$0</b>
<b><u>MENTAL HEALTH</u></b>				
224	SMHS FOR CHILDREN	\$809,852,000	\$809,852,000	\$0
225	SMHS FOR ADULTS	\$541,957,000	\$541,957,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,351,809,000</b>	<b>\$1,351,809,000</b>	<b>\$0</b>
<b><u>MANAGED CARE</u></b>				
108	TWO PLAN MODEL	\$6,926,751,000	\$3,477,291,200	\$3,449,459,800
109	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,433,225,000	\$1,723,388,600	\$1,709,836,400
110	GEOGRAPHIC MANAGED CARE	\$1,216,643,000	\$610,827,400	\$605,815,600
115	PACE (Other M/C)	\$162,892,000	\$81,446,000	\$81,446,000
117	DENTAL MANAGED CARE (Other M/C)	\$48,887,000	\$24,443,500	\$24,443,500
118	SENIOR CARE ACTION NETWORK (Other M/C)	\$34,873,000	\$17,436,500	\$17,436,500
119	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,381,000	\$6,190,500	\$6,190,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,906,000	\$1,453,000	\$1,453,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$11,838,558,000</b>	<b>\$5,942,476,700</b>	<b>\$5,896,081,300</b>
<b><u>OTHER</u></b>				
166	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,805,292,000	\$2,805,292,000	\$0
167	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,430,750,000	\$1,138,033,500	\$1,292,716,500
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,455,607,000	\$0	\$1,455,607,000
169	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,065,882,000	\$1,065,882,000	\$0
172	DENTAL SERVICES	\$435,640,000	\$221,770,850	\$213,869,150
175	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$250,517,000	\$250,517,000	\$0
176	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$145,216,000	\$145,216,000	\$0
177	EPSDT SCREENS	\$36,942,000	\$18,471,000	\$18,471,000
178	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$46,004,000	\$46,004,000	\$0
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$39,656,000	\$19,828,000	\$19,828,000
184	LAWSUITS/CLAIMS	\$4,577,000	\$2,288,500	\$2,288,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,447,000	\$1,223,500	\$1,223,500
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,859,000	\$1,859,000	\$0
202	BASE RECOVERIES	-\$294,101,000	-\$119,650,000	-\$174,451,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,426,288,000</b>	<b>\$5,596,735,350</b>	<b>\$2,829,552,650</b>

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	GRAND TOTAL	<u>\$21,713,000,000</u>	<u>\$12,987,366,050</u>	<u>\$8,725,633,950</u>

**SUMMARY OF BASE POLICY CHANGES  
FISCAL YEAR 2013-14**

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b><u>DRUG MEDI-CAL</u></b>				
53	NARCOTIC TREATMENT PROGRAM	\$61,500,000	\$61,500,000	\$0
54	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$23,490,000	\$23,490,000	\$0
55	DAY CARE REHABILITATIVE SERVICES	\$9,563,000	\$9,563,000	\$0
56	PERINATAL RESIDENTIAL SUBSTANCE USE DISORDI	\$718,000	\$718,000	\$0
57	NALTREXONE TREATMENT SERVICES	\$0	\$0	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$95,271,000</b>	<b>\$95,271,000</b>	<b>\$0</b>
<b><u>MENTAL HEALTH</u></b>				
224	SMHS FOR CHILDREN	\$775,685,000	\$775,685,000	\$0
225	SMHS FOR ADULTS	\$515,510,000	\$515,510,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,291,195,000</b>	<b>\$1,291,195,000</b>	<b>\$0</b>
<b><u>MANAGED CARE</u></b>				
108	TWO PLAN MODEL	\$7,499,108,000	\$3,764,273,200	\$3,734,834,800
109	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,384,466,000	\$1,699,237,200	\$1,685,228,800
110	GEOGRAPHIC MANAGED CARE	\$1,288,011,000	\$646,658,800	\$641,352,200
115	PACE (Other M/C)	\$220,893,000	\$110,446,500	\$110,446,500
117	DENTAL MANAGED CARE (Other M/C)	\$48,801,000	\$24,400,500	\$24,400,500
118	SENIOR CARE ACTION NETWORK (Other M/C)	\$24,100,000	\$12,050,000	\$12,050,000
119	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,526,000	\$6,263,000	\$6,263,000
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,915,000	\$1,457,500	\$1,457,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$12,480,820,000</b>	<b>\$6,264,786,700</b>	<b>\$6,216,033,300</b>
<b><u>OTHER</u></b>				
166	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,697,294,000	\$2,697,294,000	\$0
167	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,563,325,000	\$1,198,265,000	\$1,365,060,000
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,481,141,000	\$0	\$1,481,141,000
169	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,286,515,000	\$1,286,515,000	\$0
172	DENTAL SERVICES	\$506,023,000	\$256,962,350	\$249,060,650
175	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$236,509,000	\$236,509,000	\$0
176	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$159,939,000	\$159,939,000	\$0
177	EPSDT SCREENS	\$42,448,000	\$21,224,000	\$21,224,000
178	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$47,845,000	\$47,845,000	\$0
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,674,000	\$20,337,000	\$20,337,000
184	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$932,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,255,000	\$1,127,500	\$1,127,500
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$1,285,000	\$0
202	BASE RECOVERIES	-\$251,766,000	-\$102,426,000	-\$149,340,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,815,352,000</b>	<b>\$5,825,809,350</b>	<b>\$2,989,542,650</b>

**SUMMARY OF BASE POLICY CHANGES  
FISCAL YEAR 2013-14**

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	<b>GRAND TOTAL</b>	<b><u>\$22,682,638,000</u></b>	<b><u>\$13,477,062,050</u></b>	<b><u>\$9,205,575,950</u></b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2013 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2012 ESTIMATE  
FISCAL YEAR 2012-13**

NO.	POLICY CHANGE TITLE	2012-13 APPROPRIATION		NOV. 2012 EST. FOR 2012-13		MAY 2013 EST. FOR 2012-13		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>DRUG MEDI-CAL</b>											
53	NARCOTIC TREATMENT PROGRAM	\$0	\$0	\$61,799,000	\$0	\$60,389,000	\$0	\$60,389,000	\$0	-\$1,410,000	\$0
54	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$0	\$0	\$25,759,000	\$0	\$23,640,000	\$0	\$23,640,000	\$0	-\$2,119,000	\$0
55	DAY CARE REHABILITATIVE SERVICES	\$0	\$0	\$11,441,000	\$0	\$11,457,000	\$0	\$11,457,000	\$0	\$16,000	\$0
56	PERINATAL RESIDENTIAL SUBSTANCE USE DISORDEF	\$0	\$0	\$827,000	\$0	\$859,000	\$0	\$859,000	\$0	\$32,000	\$0
57	NALTREXONE TREATMENT SERVICES	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$99,826,000</b>	<b>\$0</b>	<b>\$96,345,000</b>	<b>\$0</b>	<b>\$96,345,000</b>	<b>\$0</b>	<b>-\$3,481,000</b>	<b>\$0</b>
<b>MENTAL HEALTH</b>											
60	CHILDREN, ADULT, & FFS PSYCHIATRIC INPATIENT	\$0	\$0	\$1,215,939,000	\$0	\$0	\$0	\$0	\$0	-\$1,215,939,000	\$0
224	SMHS FOR CHILDREN	\$0	\$0	\$0	\$0	\$809,852,000	\$0	\$809,852,000	\$0	\$809,852,000	\$0
225	SMHS FOR ADULTS	\$0	\$0	\$0	\$0	\$541,957,000	\$0	\$541,957,000	\$0	\$541,957,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$1,215,939,000</b>	<b>\$0</b>	<b>\$1,351,809,000</b>	<b>\$0</b>	<b>\$1,351,809,000</b>	<b>\$0</b>	<b>\$135,870,000</b>	<b>\$0</b>
<b>MANAGED CARE</b>											
108	TWO PLAN MODEL	\$6,734,508,000	\$3,353,388,800	\$6,796,111,000	\$3,384,243,300	\$6,926,751,000	\$3,449,459,800	\$192,243,000	\$96,071,000	\$130,640,000	\$65,216,500
109	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,622,780,000	\$1,804,900,500	\$3,603,868,000	\$1,795,171,900	\$3,433,225,000	\$1,709,836,400	-\$189,555,000	-\$95,064,100	-\$170,643,000	-\$85,335,500
110	GEOGRAPHIC MANAGED CARE	\$1,147,888,000	\$571,449,400	\$1,161,040,000	\$578,013,100	\$1,216,643,000	\$605,815,600	\$68,755,000	\$34,366,200	\$55,603,000	\$27,802,500
115	PACE (Other M/C)	\$175,408,000	\$87,704,000	\$170,011,000	\$85,005,500	\$162,892,000	\$81,446,000	-\$12,516,000	-\$6,258,000	-\$7,119,000	-\$3,559,500
117	DENTAL MANAGED CARE (Other M/C)	\$54,807,000	\$27,403,500	\$52,576,000	\$26,288,000	\$48,887,000	\$24,443,500	-\$5,920,000	-\$2,960,000	-\$3,689,000	-\$1,844,500
118	SENIOR CARE ACTION NETWORK (Other M/C)	\$14,944,000	\$7,472,000	\$18,283,000	\$9,141,500	\$34,873,000	\$17,436,500	\$19,929,000	\$9,964,500	\$16,590,000	\$8,295,000
119	AIDS HEALTHCARE CENTERS (Other M/C)	\$14,157,000	\$7,078,500	\$13,359,000	\$6,679,500	\$12,381,000	\$6,190,500	-\$1,776,000	-\$888,000	-\$978,000	-\$489,000
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,887,000	\$1,443,500	\$1,464,000	\$732,000	\$2,906,000	\$1,453,000	\$19,000	\$9,500	\$1,442,000	\$721,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$11,767,379,000</b>	<b>\$5,860,840,200</b>	<b>\$11,816,712,000</b>	<b>\$5,885,274,800</b>	<b>\$11,838,558,000</b>	<b>\$5,896,081,300</b>	<b>\$71,179,000</b>	<b>\$35,241,100</b>	<b>\$21,846,000</b>	<b>\$10,806,500</b>
<b>OTHER</b>											
130	MENTAL HEALTH SERVICES-CDMH	\$1,677,313,000	\$0	\$0	\$0	\$0	\$0	-\$1,677,313,000	\$0	\$0	\$0
138	DRUG MEDI-CAL-CDADP	\$154,869,000	\$0	\$0	\$0	\$0	\$0	-\$154,869,000	\$0	\$0	\$0
166	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,525,036,000	\$0	\$2,899,710,000	\$0	\$2,805,292,000	\$0	\$280,256,000	\$0	-\$94,418,000	\$0
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,485,702,000	\$1,324,429,000	\$2,495,745,000	\$1,324,485,500	\$2,430,750,000	\$1,292,716,500	-\$54,952,000	-\$31,712,500	-\$64,995,000	-\$31,769,000
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,465,483,000	\$1,465,483,000	\$1,456,141,000	\$1,456,141,000	\$1,455,607,000	\$1,455,607,000	-\$9,876,000	-\$9,876,000	-\$534,000	-\$534,000
169	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,089,699,000	\$0	\$1,245,431,000	\$0	\$1,065,882,000	\$0	-\$23,817,000	\$0	-\$179,549,000	\$0

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2013 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2012 ESTIMATE  
FISCAL YEAR 2012-13**

NO.	POLICY CHANGE TITLE	2012-13 APPROPRIATION		NOV. 2012 EST. FOR 2012-13		MAY 2013 EST. FOR 2012-13		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER</b>											
172	DENTAL SERVICES	\$526,115,000	\$259,429,900	\$441,893,000	\$217,237,150	\$435,640,000	\$213,869,150	-\$90,475,000	-\$45,560,750	-\$6,253,000	-\$3,368,000
175	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$205,349,000	\$0	\$251,686,000	\$0	\$250,517,000	\$0	\$45,168,000	\$0	-\$1,169,000	\$0
176	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$138,469,000	\$0	\$166,021,000	\$0	\$145,216,000	\$0	\$6,747,000	\$0	-\$20,805,000	\$0
177	EPSDT SCREENS	\$53,242,000	\$26,621,000	\$45,821,000	\$22,910,500	\$36,942,000	\$18,471,000	-\$16,300,000	-\$8,150,000	-\$8,879,000	-\$4,439,500
178	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$57,621,000	\$0	\$42,640,000	\$0	\$46,004,000	\$0	-\$11,617,000	\$0	\$3,364,000	\$0
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$38,751,000	\$19,375,500	\$37,995,000	\$18,997,500	\$39,656,000	\$19,828,000	\$905,000	\$452,500	\$1,661,000	\$830,500
184	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$3,661,000	\$1,830,500	\$4,577,000	\$2,288,500	\$2,712,000	\$1,356,000	\$916,000	\$458,000
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$1,471,000	\$735,500	\$2,503,000	\$1,251,500	\$2,447,000	\$1,223,500	\$976,000	\$488,000	-\$56,000	-\$28,000
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$0	\$1,769,000	\$0	\$1,859,000	\$0	\$831,000	\$0	\$90,000	\$0
202	BASE RECOVERIES	-\$266,256,000	-\$159,354,000	-\$236,954,000	-\$140,554,000	-\$294,101,000	-\$174,451,000	-\$27,845,000	-\$15,097,000	-\$57,147,000	-\$33,897,000
	<b>OTHER SUBTOTAL</b>	<b>\$10,155,757,000</b>	<b>\$2,937,652,400</b>	<b>\$8,854,062,000</b>	<b>\$2,902,299,650</b>	<b>\$8,426,288,000</b>	<b>\$2,829,552,650</b>	<b>-\$1,729,469,000</b>	<b>-\$108,099,750</b>	<b>-\$427,774,000</b>	<b>-\$72,747,000</b>
	<b>GRAND TOTAL</b>	<b>\$21,923,136,000</b>	<b>\$8,798,492,600</b>	<b>\$21,986,539,000</b>	<b>\$8,787,574,450</b>	<b>\$21,713,000,000</b>	<b>\$8,725,633,950</b>	<b>-\$210,136,000</b>	<b>-\$72,858,650</b>	<b>-\$273,539,000</b>	<b>-\$61,940,500</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2013 ESTIMATE COMPARED TO NOVEMBER 2012 ESTIMATE  
FISCAL YEAR 2013-14**

NO.	POLICY CHANGE TITLE	NOV. 2012 EST. FOR 2013-14		MAY 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>DRUG MEDI-CAL</b>							
53	NARCOTIC TREATMENT PROGRAM	\$64,173,000	\$0	\$61,500,000	\$0	-\$2,673,000	\$0
54	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$26,078,000	\$0	\$23,490,000	\$0	-\$2,588,000	\$0
55	DAY CARE REHABILITATIVE SERVICES	\$9,495,000	\$0	\$9,563,000	\$0	\$68,000	\$0
56	PERINATAL RESIDENTIAL SUBSTANCE USE DISORDER	\$673,000	\$0	\$718,000	\$0	\$45,000	\$0
57	NALTREXONE TREATMENT SERVICES	\$0	\$0	\$0	\$0	\$0	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$100,419,000</b>	<b>\$0</b>	<b>\$95,271,000</b>	<b>\$0</b>	<b>-\$5,148,000</b>	<b>\$0</b>
<b>MENTAL HEALTH</b>							
60	CHILDREN, ADULT, & FFS PSYCHIATRIC INPATIENT	\$1,190,661,000	\$0			-\$1,190,661,000	\$0
224	SMHS FOR CHILDREN			\$775,685,000	\$0	\$775,685,000	\$0
225	SMHS FOR ADULTS			\$515,510,000	\$0	\$515,510,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,190,661,000</b>	<b>\$0</b>	<b>\$1,291,195,000</b>	<b>\$0</b>	<b>\$100,534,000</b>	<b>\$0</b>
<b>MANAGED CARE</b>							
108	TWO PLAN MODEL	\$6,871,122,000	\$3,420,899,300	\$7,499,108,000	\$3,734,834,800	\$627,986,000	\$313,935,500
109	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,657,882,000	\$1,821,952,800	\$3,384,466,000	\$1,685,228,800	-\$273,416,000	-\$136,724,000
110	GEOGRAPHIC MANAGED CARE	\$1,176,207,000	\$585,440,700	\$1,288,011,000	\$641,352,200	\$111,804,000	\$55,911,500
115	PACE (Other M/C)	\$253,075,000	\$126,537,500	\$220,893,000	\$110,446,500	-\$32,182,000	-\$16,091,000
117	DENTAL MANAGED CARE (Other M/C)	\$53,418,000	\$26,709,000	\$48,801,000	\$24,400,500	-\$4,617,000	-\$2,308,500
118	SENIOR CARE ACTION NETWORK (Other M/C)	\$40,100,000	\$20,050,000	\$24,100,000	\$12,050,000	-\$16,000,000	-\$8,000,000
119	AIDS HEALTHCARE CENTERS (Other M/C)	\$14,579,000	\$7,289,500	\$12,526,000	\$6,263,000	-\$2,053,000	-\$1,026,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)			\$2,915,000	\$1,457,500	\$2,915,000	\$1,457,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$12,066,383,000</b>	<b>\$6,008,878,800</b>	<b>\$12,480,820,000</b>	<b>\$6,216,033,300</b>	<b>\$414,437,000</b>	<b>\$207,154,500</b>
<b>OTHER</b>							
166	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,403,748,000	\$0	\$2,697,294,000	\$0	\$293,546,000	\$0
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,651,874,000	\$1,409,069,000	\$2,563,325,000	\$1,365,060,000	-\$88,549,000	-\$44,009,000
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,509,021,000	\$1,509,021,000	\$1,481,141,000	\$1,481,141,000	-\$27,880,000	-\$27,880,000
169	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,165,802,000	\$0	\$1,286,515,000	\$0	\$120,713,000	\$0
172	DENTAL SERVICES	\$508,779,000	\$250,680,150	\$506,023,000	\$249,060,650	-\$2,756,000	-\$1,619,500
175	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$243,463,000	\$0	\$236,509,000	\$0	-\$6,954,000	\$0
176	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$142,042,000	\$0	\$159,939,000	\$0	\$17,897,000	\$0
177	EPSDT SCREENS	\$46,234,000	\$23,117,000	\$42,448,000	\$21,224,000	-\$3,786,000	-\$1,893,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2013 ESTIMATE COMPARED TO NOVEMBER 2012 ESTIMATE  
FISCAL YEAR 2013-14**

NO.	POLICY CHANGE TITLE	NOV. 2012 EST. FOR 2013-14		MAY 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
178	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$44,345,000	\$0	\$47,845,000	\$0	\$3,500,000	\$0
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$42,146,000	\$21,073,000	\$40,674,000	\$20,337,000	-\$1,472,000	-\$736,000
184	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$1,865,000	\$932,500	\$0	\$0
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,307,000	\$1,153,500	\$2,255,000	\$1,127,500	-\$52,000	-\$26,000
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,330,000	\$0	\$1,285,000	\$0	-\$45,000	\$0
202	BASE RECOVERIES	-\$240,243,000	-\$142,505,000	-\$251,766,000	-\$149,340,000	-\$11,523,000	-\$6,835,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,522,713,000</b>	<b>\$3,072,541,150</b>	<b>\$8,815,352,000</b>	<b>\$2,989,542,650</b>	<b>\$292,639,000</b>	<b>-\$82,998,500</b>
	<b>GRAND TOTAL</b>	<b>\$21,880,176,000</b>	<b>\$9,081,419,950</b>	<b>\$22,682,638,000</b>	<b>\$9,205,575,950</b>	<b>\$802,462,000</b>	<b>\$124,156,000</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2012-13 AND 2013-14**

NO.	POLICY CHANGE TITLE	MAY 2013 EST. FOR 2012-13		MAY 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>DRUG MEDI-CAL</u></b>							
53	NARCOTIC TREATMENT PROGRAM	\$60,389,000	\$0	\$61,500,000	\$0	\$1,111,000	\$0
54	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$23,640,000	\$0	\$23,490,000	\$0	-\$150,000	\$0
55	DAY CARE REHABILITATIVE SERVICES	\$11,457,000	\$0	\$9,563,000	\$0	-\$1,894,000	\$0
56	PERINATAL RESIDENTIAL SUBSTANCE USE DISORDI	\$859,000	\$0	\$718,000	\$0	-\$141,000	\$0
57	NALTREXONE TREATMENT SERVICES	\$0	\$0	\$0	\$0	\$0	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$96,345,000</b>	<b>\$0</b>	<b>\$95,271,000</b>	<b>\$0</b>	<b>-\$1,074,000</b>	<b>\$0</b>
<b><u>MENTAL HEALTH</u></b>							
224	SMHS FOR CHILDREN	\$809,852,000	\$0	\$775,685,000	\$0	-\$34,167,000	\$0
225	SMHS FOR ADULTS	\$541,957,000	\$0	\$515,510,000	\$0	-\$26,447,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,351,809,000</b>	<b>\$0</b>	<b>\$1,291,195,000</b>	<b>\$0</b>	<b>-\$60,614,000</b>	<b>\$0</b>
<b><u>MANAGED CARE</u></b>							
108	TWO PLAN MODEL	\$6,926,751,000	\$3,449,459,800	\$7,499,108,000	\$3,734,834,800	\$572,357,000	\$285,375,000
109	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,433,225,000	\$1,709,836,400	\$3,384,466,000	\$1,685,228,800	-\$48,759,000	-\$24,607,600
110	GEOGRAPHIC MANAGED CARE	\$1,216,643,000	\$605,815,600	\$1,288,011,000	\$641,352,200	\$71,368,000	\$35,536,600
115	PACE (Other M/C)	\$162,892,000	\$81,446,000	\$220,893,000	\$110,446,500	\$58,001,000	\$29,000,500
117	DENTAL MANAGED CARE (Other M/C)	\$48,887,000	\$24,443,500	\$48,801,000	\$24,400,500	-\$86,000	-\$43,000
118	SENIOR CARE ACTION NETWORK (Other M/C)	\$34,873,000	\$17,436,500	\$24,100,000	\$12,050,000	-\$10,773,000	-\$5,386,500
119	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,381,000	\$6,190,500	\$12,526,000	\$6,263,000	\$145,000	\$72,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,906,000	\$1,453,000	\$2,915,000	\$1,457,500	\$9,000	\$4,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$11,838,558,000</b>	<b>\$5,896,081,300</b>	<b>\$12,480,820,000</b>	<b>\$6,216,033,300</b>	<b>\$642,262,000</b>	<b>\$319,952,000</b>
<b><u>OTHER</u></b>							
166	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,805,292,000	\$0	\$2,697,294,000	\$0	-\$107,998,000	\$0
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,430,750,000	\$1,292,716,500	\$2,563,325,000	\$1,365,060,000	\$132,575,000	\$72,343,500
168	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,455,607,000	\$1,455,607,000	\$1,481,141,000	\$1,481,141,000	\$25,534,000	\$25,534,000
169	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,065,882,000	\$0	\$1,286,515,000	\$0	\$220,633,000	\$0
172	DENTAL SERVICES	\$435,640,000	\$213,869,150	\$506,023,000	\$249,060,650	\$70,383,000	\$35,191,500
175	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$250,517,000	\$0	\$236,509,000	\$0	-\$14,008,000	\$0

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

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2012-13 AND 2013-14**

NO.	POLICY CHANGE TITLE	MAY 2013 EST. FOR 2012-13		MAY 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>OTHER</b>						
176	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$145,216,000	\$0	\$159,939,000	\$0	\$14,723,000	\$0
177	EPSDT SCREENS	\$36,942,000	\$18,471,000	\$42,448,000	\$21,224,000	\$5,506,000	\$2,753,000
178	MEDI-CAL TCM PROGRAM (Misc. Svcs.)	\$46,004,000	\$0	\$47,845,000	\$0	\$1,841,000	\$0
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$39,656,000	\$19,828,000	\$40,674,000	\$20,337,000	\$1,018,000	\$509,000
184	LAWSUITS/CLAIMS	\$4,577,000	\$2,288,500	\$1,865,000	\$932,500	-\$2,712,000	-\$1,356,000
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,447,000	\$1,223,500	\$2,255,000	\$1,127,500	-\$192,000	-\$96,000
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,859,000	\$0	\$1,285,000	\$0	-\$574,000	\$0
202	BASE RECOVERIES	-\$294,101,000	-\$174,451,000	-\$251,766,000	-\$149,340,000	\$42,335,000	\$25,111,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,426,288,000</b>	<b>\$2,829,552,650</b>	<b>\$8,815,352,000</b>	<b>\$2,989,542,650</b>	<b>\$389,064,000</b>	<b>\$159,990,000</b>
	<b>GRAND TOTAL</b>	<b>\$21,713,000,000</b>	<b>\$8,725,633,950</b>	<b>\$22,682,638,000</b>	<b>\$9,205,575,950</b>	<b>\$969,638,000</b>	<b>\$479,942,000</b>

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

## MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>DRUG MEDI-CAL</u></b>	
53	NARCOTIC TREATMENT PROGRAM
54	OUTPATIENT DRUG FREE TREATMENT SERVICES
55	DAY CARE REHABILITATIVE SERVICES
56	PERINATAL RESIDENTIAL SUBSTANCE USE DISORDER SVS
57	NALTREXONE TREATMENT SERVICES
<b><u>MENTAL HEALTH</u></b>	
224	SMHS FOR CHILDREN
225	SMHS FOR ADULTS
<b><u>MANAGED CARE</u></b>	
108	TWO PLAN MODEL
109	COUNTY ORGANIZED HEALTH SYSTEMS
110	GEOGRAPHIC MANAGED CARE
115	PACE (Other M/C)
117	DENTAL MANAGED CARE (Other M/C)
118	SENIOR CARE ACTION NETWORK (Other M/C)
119	AIDS HEALTHCARE CENTERS (Other M/C)
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
<b><u>OTHER</u></b>	
166	PERSONAL CARE SERVICES (Misc. Svcs.)
167	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
168	MEDICARE PAYMENTS - PART D PHASED-DOWN
169	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)
172	DENTAL SERVICES
175	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
176	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
177	EPSDT SCREENS
178	MEDI-CAL TCM PROGRAM (Misc. Svcs.)
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
184	LAWSUITS/CLAIMS
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

**MEDI-CAL PROGRAM BASE  
POLICY CHANGE INDEX**

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b>OTHER</b>
202	BASE RECOVERIES

## NARCOTIC TREATMENT PROGRAM

**BASE POLICY CHANGE NUMBER:** 53  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1728

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$60,389,000	\$61,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$60,389,000	\$61,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$60,389,000	\$61,500,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal reimbursement funds for the Drug Medi-Cal (DMC), Narcotic Treatment Program's (NTP) daily methadone dosing service.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(14); 51341.1 (d)(1); 51516.1 (a)  
 AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The NTP daily methadone dosing service is provided to opiate addicted beneficiaries who have substance use disorder diagnoses, and/or who are Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible. Methadone and/or levoalphacetylmethadol (LAAM) are used as one component of a comprehensive treatment program for narcotic addiction, along with a medical evaluation, treatment planning, and counseling. These synthetic opiates used in replacement narcotic therapy, appear to normalize brain chemistry and permit resumption of a normal life. In 2003, LAAM distribution was discontinued in the United States due to reports of cardiac problems. Effective FY 2006-07, the Department of Alcohol and Drug Program (ADP) stopped producing a DMC reimbursement rate for LAAM daily dosing.

Through Fiscal Year (FY) 2010-11, the local assistance General Fund (GF) for perinatal services were budgeted in ADP's perinatal appropriation item 4200-102-0001. The local assistance GF for non-perinatal services was budgeted in ADP's appropriation item 4200-103-0001. Effective July 1, 2011, the local assistance GF was realigned to counties as County Funds (CF).

Effective July 1, 2012, DMC services transferred from ADP to the Department. The Department budgets the local assistance federal reimbursement funds for DMC services in appropriation item 4260-101-0890.

## NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 53

### Reason for Change from Prior Estimate:

There is no material change.

### Methodology:

1. The DMC eligible clients are categorized into four groups: Regular, Minor Consent, EPSDT, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports have not been finalized, the four quarters, July 2011 through June 2012, were not included in determining the caseload projections.
4. The Units of Service (UOS) is based on July 2010-June 2011 to calculate an average UOS.
5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by Department of Finance, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

<u>Narcotic Treatment</u>	<u>FY 2009-10 UOS Rate</u>	<u>CIP Deflator</u>	<u>FY 2012-13 Rates*</u>	<u>FY 2012-13 Developed Rates</u>	<u>FY 2012-13 Required Rates</u>
Regular					
Dosing	\$11.34	7.1%	\$12.15	\$11.97	\$11.97
Individual	\$13.30	7.1%	\$14.24	\$16.60	\$14.24
Group	\$3.14	7.1%	\$3.36	\$3.54	\$3.36
Perinatal					
Dosing	\$12.21	7.1%	\$13.08	\$13.05	\$13.05
Individual	\$19.04	7.1%	\$20.39	\$25.11	\$20.39
Group	\$6.36	7.1%	\$6.81	\$6.89	\$6.81

\*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 53**

6. The cost estimate is developed by the following, Caseload x Units of Service (UOS) x Rates:

**FY 2012-13**

<b>DMC Regular</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
Regular				
Dosing	83,103	75.0	\$11.97	\$74,606,000
Group	83,103	0.2	\$3.36	\$56,000
Individual	83,103	34.8	\$14.24	\$41,182,000
Total				\$115,843,000
EPSDT				
Dosing	777	68.8	\$11.97	\$640,000
Group	777	0.2	\$3.36	\$500
Individual	777	33.1	\$14.24	\$366,000
Total				\$1,007,000
Minor Consent				
Dosing	457	9.0	\$11.97	\$49,000
Group	457	0.0	\$3.36	\$0
Individual	457	5.0	\$14.24	\$33,000
Total				\$82,000
Perinatal				
Dosing	1,948	9.7	\$13.05	\$247,000
Group	1,948	0.1	\$6.81	\$1,000
Individual	1,948	3.7	\$20.39	\$147,000
Total				\$395,000

**FY 2013-14**

<b>DMC Regular</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
Regular				
Dosing	88,493	75.0	\$11.97	\$79,445,000
Group	88,493	0.2	\$3.36	\$59,000
Individual	88,493	34.8	\$14.24	\$43,853,000
Total				\$123,357,000
EPSDT				
Dosing	878	68.8	\$11.97	\$723,000
Group	878	0.2	\$3.36	\$600
Individual	878	33.1	\$14.24	\$414,000
Total				\$1,137,600
Minor Consent				
Dosing	517	9.0	\$11.97	\$56,000
Group	517	0.0	\$3.36	\$0
Individual	517	5.0	\$14.24	\$37,000
Total				\$93,000

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 53**

Perinatal				
Dosing	2,097	9.7	\$13.05	\$265,000
Group	2,097	0.1	\$6.81	\$1,000
Individual	2,097			\$158,000
Total		3.7	\$20.39	\$425,000

Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2012-13</u>	<u>FY 2013-14</u>
DMC Regular & EPSDT	\$130,890,000	\$32,723,000	\$0
Minor Consent	\$42,000	\$11,000	\$0
DMC Perinatal	\$485,000	\$121,000	\$0
FY 2011-12	\$131,418,000	\$32,855,000	\$0
DMC Regular & EPSDT	\$116,850,000	\$87,638,000	\$29,213,000
Minor Consent	\$ 82,000	\$61,000	\$20,000
DMC Perinatal	\$ 395,000	\$296,000	\$99,000
FY 2012-13	\$117,327,000	\$87,995,000	\$29,332,000
DMC Regular & EPSDT	\$124,494,000	\$0	\$93,371,000
Minor Consent	\$ 93,000	\$0	\$69,000
DMC Perinatal	\$ 425,000	\$0	\$319,000
FY 2013-14	\$125,012,000	\$0	\$93,759,000

7. Below the costs are on a cash basis.

	<u>Regular</u>	<u>Minor Consent</u>	<u>Perinatal</u>
FY 2011-12	\$32,723,000	\$11,000	\$121,000
FY 2012-13	\$87,638,000	\$61,000	\$296,000
Total FY 2012-13	\$120,360,000	\$72,000	\$417,000
FY 2012-13	\$29,213,000	\$20,000	\$99,000
FY 2013-14	\$93,371,000	\$69,000	\$319,000
Total FY 2013-14	\$122,583,000	\$90,000	\$418,000

8. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consent costs are funded by the counties.

	<u>TF</u>	<u>FFP</u>	<u>CF</u>
DMC Regular	\$120,432,000	\$60,180,000	\$60,252,000
DMC Perinatal	\$417,000	\$209,000	\$209,000
<b>Total FY 2012-13</b>	<b>\$120,849,000</b>	<b>\$60,389,000</b>	<b>\$60,461,000</b>

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 53

	<u>TF</u>	<u>FFP</u>	<u>CF</u>
DMC Regular	\$122,673,000	\$61,292,000	\$61,381,000
DMC Perinatal	\$418,000	\$209,000	\$209,000
<b>Total FY 2013-14</b>	<b>\$123,091,000</b>	<b>\$61,500,000</b>	<b>\$61,590,000</b>

**Funding:**

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

Title XXI 100% FFP (4260-113-0890)

## OUTPATIENT DRUG FREE TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 54  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1727

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$23,640,000	\$23,490,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,640,000	\$23,490,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$23,640,000	\$23,490,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal reimbursement funds for the Drug Medi-Cal (DMC), Outpatient Drug Free (ODF) counseling treatment service.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(15); 51341.1 (d)(2); 51516.1 (a)  
 AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

ODF counseling treatment services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance use disorder diagnosis in an outpatient setting. This includes services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Each ODF participant receives at least two group, face-to-face, counseling sessions per month. Counseling and rehabilitation services include:

- Admission physical examinations,
- Intake,
- Medical necessity establishment,
- Medication services,
- Treatment and discharge planning,
- Crisis intervention,
- Collateral services, and
- Individual and group counseling.

Through Fiscal Year (FY) 2010-11, the local assistance General Fund (GF) for ODF counseling treatment services were budgeted in the Department of Alcohol and Drug Programs (ADP) perinatal appropriation item 4200-102-001. The local assistance GF for non-perinatal services was budgeted in ADP's appropriation item 4200-103-0001. Effective July 1, 2011, the local assistance GF was

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

realigned to counties as County Funds (CF).

Effective July 1, 2012, DMC services transferred from ADP to the Department. The Department budgets the local assistance federal reimbursement funds for DMC services in appropriation item 4260-101-0890.

### Reason for Change from Prior Estimate:

There is no material change.

### Methodology:

1. The DMC eligible clients are categorized into four groups: Regular, Minor Consent, EPSDT, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports are not finalized, the four quarters, July 2011 through June 2012, are not included in determining the caseload projections.
4. The Units of Service (UOS) data is applied to the four most recent complete quarters, July 2010 through June 2011, to calculate an average UOS.
5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by DOF, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 required rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

DCR	FY 2009-10 UOS Rate	CIP Deflator	FY 2012-13 Rates*	FY 2012-13 Developed Rates	FY 2012-13 Required Rates
Regular					
Individual	\$66.53	7.1%	\$71.25	\$82.98	\$71.25
Group	\$28.27	7.1%	\$30.28	\$31.84	\$30.28
Perinatal					
Individual	\$95.23	7.1%	\$101.99	\$125.57	\$101.99
Group	\$57.26	7.1%	\$61.33	\$62.05	\$61.33

\*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

**OUTPATIENT DRUG FREE TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 54

6. The cost estimate is developed by the following, Caseload x UOS x Rates:

**FY 2012-13**

<u>DMC</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
Regular				
Group	78,828	12.8	\$30.28	\$30,552,000
Individual	78,828	1.2	\$71.25	\$6,740,000
Total				\$37,292,000
EPSDT				
Group	45,009	4.4	\$30.28	\$5,997,000
Individual	45,009	0.8	\$71.25	\$2,566,000
Total				\$8,562,000
Minor Consent				
Group	26,514	17.0	\$30.28	\$13,648,000
Individual	26,514	1.9	\$71.25	\$3,589,000
Total				\$17,238,000
Perinatal				
Group	3,219	1.8	\$61.33	\$355,000
Individual	3,219	0.2	\$101.99	\$66,000
Total				\$421,000

**FY 2013-14**

<u>DMC</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
Regular				
Group	79,467	12.8	\$30.28	\$30,800,000
Individual	79,467	1.2	\$71.25	\$6,794,000
Total				\$37,595,000
EPSDT				
Group	48,410	4.4	\$30.28	\$6,450,000
Individual	48,410	0.8	\$71.25	\$2,759,000
Total				\$9,209,000
Minor Consent				
Group	28,517	17.0	\$30.28	\$14,679,000
Individual	28,517	1.9	\$71.25	\$3,860,000
Total				\$18,540,000
Perinatal				
Group	3,142	1.8	\$61.33	\$347,000
Individual	3,142	0.2	\$101.99	\$64,000
Total				\$411,000

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

7. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year. Below the costs are on an accrual basis.

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2012-13</u>	<u>FY 2013-14</u>
DMC Regular	\$49,844,000	\$12,461,000	\$0
Minor Consent	\$13,535,000	\$3,384,000	\$0
DMC Perinatal	\$447,000	\$112,000	\$0
FY 2011-12	\$63,826,000	\$15,957,000	\$0

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2012-13</u>	<u>FY 2013-14</u>
DMC Regular	\$45,854,000	\$34,391,000	\$11,464,000
Minor Consent	\$17,238,000	\$12,928,000	\$4,309,000
DMC Perinatal	\$421,000	\$316,000	\$105,000
FY 2012-13	\$63,513,000	\$47,635,000	\$15,878,000

DMC Regular	\$ 46,804,000	\$0	\$35,103,000
Minor Consent	\$ 18,540,000	\$0	\$13,905,000
DMC Perinatal	\$ 411,000	\$0	\$308,000
FY 2013-14	\$ 65,755,000	\$0	\$49,316,000

8. Below the costs are on a cash basis.

	<u>Regular</u>	<u>Perinatal</u>	<u>Minor Consent</u>
FY 2011-12	\$12,461,000	\$112,000	\$3,384,000
FY 2012-13	\$34,391,000	\$316,000	\$12,928,000
Total FY 2012-13	\$46,852,000	\$428,000	\$16,312,000
FY 2012-13	\$11,464,000	\$105,000	\$4,309,000
FY 2013-14	\$35,103,000	\$308,000	\$13,905,000
Total FY 2013-14	\$46,566,000	\$413,000	\$18,214,000

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 54

9. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consent costs are funded by the counties.

<u>FY 2012-13</u>	<u>TF</u>	<u>FFP</u>	<u>CF</u>
DMC Regular (plus Minor Consent)	\$63,164,000	\$23,426,000	\$39,738,000
DMC Perinatal	\$428,000	\$214,000	\$214,000
<b>Total FY 2012-13</b>	<b>\$63,591,000</b>	<b>\$23,640,000</b>	<b>\$39,952,000</b>

<u>FY 2013-14</u>	<u>TF</u>	<u>FFP</u>	<u>CF</u>
DMC Regular (plus Minor Consent)	\$64,781,000	\$23,283,000	\$41,498,000
DMC Perinatal	\$413,000	\$207,000	\$207,000
<b>Total FY 2013-14</b>	<b>\$65,194,000</b>	<b>\$23,490,000</b>	<b>\$41,704,000</b>

**Funding:**

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

Title XXI 100% FFP (4260-113-0890)

## DAY CARE REHABILITATIVE SERVICES

**BASE POLICY CHANGE NUMBER:** 55  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1726

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$11,457,000</b>	<b>\$9,563,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$11,457,000</b>	<b>\$9,563,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$11,457,000</b>	<b>\$9,563,000</b>

### DESCRIPTION

**Purpose:**

This policy change estimates the federal reimbursement funds for the Drug Medi-Cal (DMC), Day Care Rehabilitative (DCR) services.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(6); 51341.1 (d)(3), and 51516.1 (a)  
 AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

DCR services are provided to beneficiaries with substance use disorder diagnoses, who are pregnant or in the postpartum period, and/or are Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible. Outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include:

- Intake,
- Admission physical examinations,
- Treatment planning,
- Individual and group counseling,
- Parenting education,
- Medication Services,
- Collateral services, and
- Crisis intervention.

Through Fiscal Year (FY) 2010-11, the local assistance General Fund (GF) for perinatal services were budgeted in the Department of Alcohol and Drug Program's (ADP) perinatal appropriation item 4200-102-0001. The local assistance GF for non-perinatal services was budgeted in ADP's appropriation item 4200-103-0001. Effective July 1, 2011, the local assistance GF was realigned to counties as

**DAY CARE REHABILITATIVE SERVICES**

BASE POLICY CHANGE NUMBER: 55

County Funds (CF).

Effective July 1, 2012, DMC services transferred from ADP to the Department. The Department budgets the local assistance federal reimbursement funds for DMC services in appropriation item 4260-101-0890.

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. The DMC eligible clients are categorized into three groups: Regular, EPSDT, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports have not been finalized, the four quarters, July 2011 through June 2012, were not included in determining the caseload projections.
4. The Units of Service (UOS) is based on July 2010-June 2011 to calculate an average UOS.
5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

<u>DCR</u>	<u>FY 2009-10 UOS Rate</u>	<u>CIP Deflator</u>	<u>FY 2012-13 Rates *</u>	<u>FY 2012-13 Developed Rates</u>	<u>FY 2012-13 Required Rates</u>
Regular	\$61.05	7.1%	\$65.38	\$67.79	\$65.38
Perinatal	\$73.04	7.1%	\$78.23	\$80.64	\$78.23

\*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

6. The cost estimate is developed by the following, Caseload x UOS x Rates:

**FY 2012-13**

<u>DCR</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
Regular & EPSDT	7,393	41.8	\$65.38	\$20,204,000
Perinatal	604	16.3	\$78.23	\$770,000

**DAY CARE REHABILITATIVE SERVICES**

BASE POLICY CHANGE NUMBER: 55

**FY 2013-14**

<u>DCR</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
Regular & EPSDT	6,538	41.8	\$65.38	\$17,868,000
Perinatal	503	16.3	\$78.23	\$641,000

7. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2012-13</u>	<u>FY 2013-14</u>
DMC Regular	\$27,872,000	\$6,968,000	\$0
DMC Perinatal	\$859,000	\$215,000	\$0
FY 2011-12	\$28,731,000	\$7,183,000	\$0
DMC Regular	\$20,204,000	\$15,153,000	\$5,051,000
DMC Perinatal	\$770,000	\$578,000	\$193,000
FY 2012-13	\$20,974,000	\$15,731,000	\$5,244,000
DMC Regular	\$17,868,000	\$0	\$13,401,000
DMC Perinatal	\$641,000	\$0	\$481,000
FY 2013-14	\$18,509,000	\$0	\$13,882,000

8. Below the costs are on a cash basis.

	<u>Regular</u>	<u>Perinatal</u>
FY 2011-12	\$6,968,000	\$215,000
FY 2012-13	\$15,153,000	\$578,000
Total FY 2012-13	\$22,121,000	\$792,000
FY 2012-13	\$5,051,000	\$193,000
FY 2013-14	\$13,401,000	\$481,000
Total FY 2013-14	\$18,452,000	\$674,000

9. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consent costs are funded by the counties.

	<u>TF</u>	<u>FFP</u>	<u>County</u>
DMC Regular	\$22,121,000	\$11,061,000	\$11,061,000
DMC Perinatal	\$792,000	\$396,000	\$396,000
<b>Total FY 2012-13</b>	<b>\$22,914,000</b>	<b>\$11,457,000</b>	<b>\$11,457,000</b>

**DAY CARE REHABILITATIVE SERVICES**

BASE POLICY CHANGE NUMBER: 55

	<u>TF</u>	<u>FFP</u>	<u>County</u>
DMC Regular	\$18,452,000	\$9,226,000	\$9,226,000
DMC Perinatal	\$674,000	\$337,000	\$337,000
<b>Total FY 2013-14</b>	<b>\$19,125,000</b>	<b>\$9,563,000</b>	<b>\$9,563,000</b>

**Funding:**

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

Title XXI 100% FFP (4260-113-0890)

## PERINATAL RESIDENTIAL SUBSTANCE USE DISORDER SVS

**BASE POLICY CHANGE NUMBER:** 56  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1725

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$859,000	\$718,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$859,000	\$718,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$859,000	\$718,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal reimbursement funds for the Drug Medi-Cal (DMC), Perinatal Residential Service.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(17); 51341.1 (d)(4); 51516.1 (a)  
 AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Perinatal Residential Service provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

Supervision and treatment services are available day and night, seven days a week. The service provides a range of activities for pregnant and postpartum women such as:

- Mother/Child habilitative and rehabilitative services,
- Service access (i.e. transportation to treatment),
- Education to reduce harmful effects of alcohol and drug on the mother and fetus or infant, and/or
- Coordination of ancillary services.

The services are reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents. Room and board is not reimbursable through the Medi-Cal program.

**PERINATAL RESIDENTIAL SUBSTANCE USE DISORDER**  
**SVS**  
**BASE POLICY CHANGE NUMBER: 56**

Through Fiscal Year (FY) 2010-11, the local assistance General Fund (GF) for perinatal services were budgeted in the Department of Alcohol and Drug Programs' (ADP) DMC services appropriation item 4200-102-0001. The local assistance GF for non-perinatal services was budgeted in ADP's appropriation item 4200-103-0001. Effective July 1, 2011, the local assistance GF was realigned to counties as County Funds (CF).

Effective July 1, 2012, DMC services transferred from ADP to the Department. The Department budgets the local assistance federal reimbursement funds for DMC services in appropriation item 4260-101-0890.

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. The caseload projections are based on the 20 most recent complete quarters of caseload data, July 2006 through June 2011. Since FY 2011-12 cost reports have not been finalized, the four quarters, July 2011 through June 2012, were not included in determining the caseload projections.
2. The Units of Service (UOS) is based on July 2010-June 2011 to calculate an average UOS.
3. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2012-13 and FY 2013-14 budgeted amounts are based on the FY 2012-13 rates. For more information about the FY 2013-14 rates, see the Annual Rate Adjustment policy change.

<u>Description</u>	<u>FY 2009-10 UOS Rate</u>	<u>CIP Deflator</u>	<u>FY 2012-13 Rates*</u>	<u>FY 2012-13 Developed Rates</u>	<u>FY 2012-13 Required Rates</u>
Perinatal	\$89.90	7.1%	\$96.28	\$110.90	\$96.28

\* Rates calculation: FY 2009-10 rates adjusted by the CIP deflator.

4. The cost estimate is developed by the following, Caseload x UOS x Rates:

<u>FY 2012-13</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
DMC Perinatal	867	18.9	\$96.28	\$1,578,000
<u>FY 2013-14</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
DMC Perinatal	763	18.9	\$96.28	\$1,388,000

5. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FY 2011-12	\$2,138,000	\$535,000	\$0
FY 2012-13	\$1,578,000	\$1,183,000	\$394,000
FY 2013-14	\$1,388,000	\$0	\$1,041,000

**PERINATAL RESIDENTIAL SUBSTANCE USE DISORDER**  
**SVS**  
**BASE POLICY CHANGE NUMBER: 56**

6. Below the costs are on a cash basis.

	<u>Perinatal</u>
FY 2011-12	\$535,000
FY 2012-13	\$1,183,000
Total FY 2012-13	<u>\$1,718,000</u>

	<u>Perinatal</u>
FY 2012-13	\$394,000
FY 2013-14	\$1,041,000
Total FY 2013-14	<u>\$1,436,000</u>

7. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consents costs are funded by the counties.

<b>FY 2012-13</b>	<u>TF</u>	<u>FFP</u>	<u>CF</u>
DMC Perinatal	\$1,718,000	<b>\$859,000</b>	\$859,000
<b>FY 2013-14</b>	<u>TF</u>	<u>FFP</u>	<u>CF</u>
DMC Perinatal	\$1,436,000	<b>\$718,000</b>	\$718,000

**Funding:**

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

Title XXI 100% FFP (4260-113-0890)

## NALTREXONE TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 57  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1743

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
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 federal reimbursement funds for the Drug Medi-Cal (DMC), Naltrexone treatment service.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(13), 51341.1 (d)(5), and 51516.1 (a) AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

This outpatient treatment service is directed at serving detoxified opioid-dependent patients who have a substance use disorder diagnosis. Naltrexone treatment services shall only be provided to a beneficiary who:

- Has a confirmed, documented history of opiate addiction,
- Is at least 18 years of age,
- Is opiate free, and
- Is not pregnant.

The Naltrexone medication blocks the euphoric effects of opioids and helps prevent relapse to opioid addiction. Naltrexone treatment services include:

- Intake,
- Admission physical examinations,
- Treatment planning,
- Provision of medication services,
- Individual and group counseling,

## NALTREXONE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 57

- Collateral services, and
- Crisis intervention.

Through FY 2010-11, the local assistance General Fund (GF) for the Naltrexone treatment service was budgeted in the Department of Alcohol and Drug Programs' (ADP) DMC services appropriation item 4200-103-0001. Effective July 1, 2011, the local assistance GF was realigned to counties as County Funds (CF).

Effective July 1, 2012, DMC services transferred from ADP to the Department. The Department budgets the local assistance federal reimbursement funds in appropriation item 4260-101-0890.

### **Reason for Change from Prior Estimate:**

There is no change.

### **Methodology:**

1. For FY 2012-13 and FY 2013-14, funding is 50% FFP and 50% CF.
2. Minor consent costs are funded by the counties.
3. While the treatment services are available and Naltrexone is still manufactured, beneficiaries are not utilizing this service.

### **Funding:**

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

## TWO PLAN MODEL

**BASE POLICY CHANGE NUMBER:** 108  
**IMPLEMENTATION DATE:** 7/2000  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 56

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$6,926,751,000	\$7,499,108,000
- STATE FUNDS	\$3,449,459,800	\$3,734,834,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,926,751,000	\$7,499,108,000
STATE FUNDS	\$3,449,459,800	\$3,734,834,800
FEDERAL FUNDS	\$3,477,291,200	\$3,764,273,200

### DESCRIPTION

#### Purpose

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

#### Authority:

Welfare & Institutions Code 14087.3

#### Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

#### Background:

Under the Two-Plan model, each designated county has two managed care plans, a local initiative and a commercial plan, which provide medically necessary services to Medi-Cal beneficiaries residing within the county. There are 14 counties in the Two Plan Model: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Beginning January 1, 2013, Health Plan of San Joaquin will replace Anthem in Stanislaus County, and Health Net will replace Anthem in San Joaquin County.

#### Reason for Change from Prior Estimate:

Updated rates were used for the calculations, and the value of potentially preventable admissions, NF-B rate changes, Cost-Based Reimbursement Clinic payments, Hospital QAF payments, public hospital IGTs, and retroactive rate increases was accounted for.

#### Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year

## TWO PLAN MODEL

### BASE POLICY CHANGE NUMBER: 108

of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.
3. The FY 2012-13 and FY 2013-14 rates include:
  - Annual rate redeterminations for FY 2012-13 and FY 2013-14.
  - An adjustment for pharmacy avoidable costs.
4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through June 30, 2012. The Department has proposed legislation that would extend the tax through June 30, 2013. The Administration is also proposing legislation for an MCO tax to apply the statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013.
5. Capitation rate increases due to the Gross Premium Tax and the MCO 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 General Fund, the Extend Gross Premium Tax – Funding Adjustment, and the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
6. The Department receives federal reimbursement of 90% for family planning services.
7. Adjustments have been made to show the value of the NF-B rate changes, Cost-Based Reimbursement Clinics, IGTs due to SB 208 (Chapter 714, Statutes of 2010), and Quality Assurance Fee Program payments due to SB 335 (Chapter 286, Statutes of 2011). These items were included in the rates, but are budgeted for elsewhere.
8. An adjustment has been made to show the value of the Potentially Preventable Admissions. These savings were included in the rate calculations, but are budgeted for elsewhere.

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 108**

(Dollars in Thousands)

<b>FY 2012-13</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	1,963,142	\$537,014
Contra Costa	1,100,204	\$284,917
Kern	1,932,074	\$368,617
Los Angeles	17,930,139	\$3,530,740
Riverside	3,302,942	\$638,999
San Bernardino	3,942,667	\$755,168
San Francisco	869,707	\$358,768
San Joaquin	1,530,342	\$305,038
Santa Clara	1,879,047	\$434,560
Stanislaus	977,926	\$165,256
Tulare	1,448,928	\$268,089
Fresno	2,810,681	\$598,564
Kings	298,453	\$52,378
Madera	362,771	\$60,034
Total FY 2012-13	40,349,023	\$8,358,142
PPA Adjustment		\$24,688
NF-B Adjustment		(\$2,784)
CBRC Adjustment		(\$100,302)
Public Hospital IGT Adjustment		(\$370,816)
Hospital QAF Adjustment		(\$877,266)
Retro Rate Increase Adjustment		(\$104,911)
<b>Total with Adjustments</b>		<b>\$6,926,751</b>

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 108**

<b>FY 2013-14</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	2,023,381	\$495,776,000
Contra Costa	1,125,109	\$262,110,000
Kern	1,970,351	\$343,968,000
Los Angeles	18,103,708	\$3,290,135,000
Riverside	3,372,940	\$595,673,000
San Bernardino	4,066,377	\$712,024,000
San Francisco	891,264	\$294,794,000
San Joaquin	1,555,454	\$298,693,000
Santa Clara	1,934,730	\$394,450,000
Stanislaus	954,224	\$196,480,000
Tulare	1,472,894	\$252,794,000
Fresno	2,859,417	\$564,642,000
Kings	300,108	\$55,427,000
Madera	370,100	\$62,304,000
<b>Total FY 2013-14</b>	<b>41,000,057</b>	<b>\$7,819,270</b>
PPA Adjustment		\$24,688
NF-B Adjustment		(\$6,545)
CBRC Adjustment		(\$24,358)
Public Hospital IGT Adjustment		(\$87,545)
Hospital QAF Adjustment		(\$226,402)
<b>Total with Adjustment</b>		<b>\$7,499,108</b>

**Funding:**

(in Thousands)

**FY 2012-13:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$3,422,879	\$3,422,879	\$6,845,758
State GF	4260-101-0001	\$20,535		\$20,535
Family Planning 90/10 GF	4260-101-0001/0890	\$6,046	\$54,412	\$60,458
<b>Total</b>		<b>\$3,449,460</b>	<b>\$3,394,365</b>	<b>\$6,926,751</b>

**FY 2013-14:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$3,708,246	\$3,708,246	\$7,416,491
State GF	4260-101-0001	\$20,364		\$20,364
Family Planning 90/10 GF	4260-101-0001/0890	\$6,225	\$56,028	\$62,253
<b>Total</b>		<b>\$3,734,835</b>	<b>\$3,764,274</b>	<b>\$7,499,108</b>

## COUNTY ORGANIZED HEALTH SYSTEMS

**BASE POLICY CHANGE NUMBER:** 109  
**IMPLEMENTATION DATE:** 12/1987  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 57

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$3,433,225,000	\$3,384,466,000
- STATE FUNDS	\$1,709,836,400	\$1,685,228,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,433,225,000	\$3,384,466,000
STATE FUNDS	\$1,709,836,400	\$1,685,228,800
FEDERAL FUNDS	\$1,723,388,600	\$1,699,237,200

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 130 Discontinue Undocumented Beneficiaries from PHC  
 PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

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

COHS will expand from 14 to 16 counties, beginning June 1, 2013. The two newly added counties are San Benito (#516) and Lake (#511). Central California Alliance for Health is the health plan contracted in the county of San Benito, while Partnership Health Plan of California is contracted in the county of Lake. These expansion counties are budgeted in Policy Change 132 Managed Care Expansion to Rural Counties.

## COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 109

### Reason for Change from Prior Estimate:

Updated rates were used for the calculations, and the value of potentially preventable admissions, NF-B rate changes, Community Based Adult Services payments, Hospital QAF payments, and retroactive rate increases was accounted for.

### Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.
2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.
3. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA). PHC is negotiating with the Department to remove OBRA beneficiaries from their contract effective January 1, 2013.
4. The FY 2012-13 and FY 2013-14 rates include:
  - Annual rate redeterminations for FY 2012-13 and FY 2013-14.
  - An adjustment for pharmacy avoidable costs.
5. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the Gross Premium Tax through June 30, 2012. The Administration is proposing legislation to extend the Gross Premium Tax through June 30, 2013. The Administration is also proposing legislation for an MCO tax to apply the statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change. For additional information on the gross premium tax extension, see the Extend Gross Premium Tax – Incr. Capitation Rates and the Extend Gross Premium Tax-Funding Adjustment policy changes.
6. Capitation rate increases due to the Gross Premium Tax and MCO 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/Sales tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to General Fund and MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
7. The Department receives federal reimbursement of 90% for family planning services.
8. The FY 2013-14 rate adjustment is included in this policy change.
9. This policy change includes adjustments for the impact of NF-B rate changes, SB 335 Hospital Quality Assurance Fee, and the retro rate increase. These are included elsewhere in the Estimate.

**COUNTY ORGANIZED HEALTH SYSTEMS****BASE POLICY CHANGE NUMBER: 109**

10. This policy change includes an adjustment for potentially preventable admissions. These savings are budgeted elsewhere in the estimate.

(Dollars in Thousands) <b>FY 2012-13</b>	<b>Eligible Months</b>	<b>Total</b>
San Luis Obispo	335,800	\$104,117
Santa Barbara	756,173	\$227,584
San Mateo	730,797	\$359,133
Solano	720,339	\$254,532
Santa Cruz	412,706	\$132,810
CalOPTIMA(Orange)	4,566,328	\$1,285,359
Napa	167,462	\$59,718
Monterey	888,194	\$249,880
Yolo	321,068	\$107,165
Sonoma	645,766	\$227,017
Merced	877,846	\$242,292
Marin	204,331	\$94,377
Mendocino	241,342	\$86,521
Ventura	1,193,876	\$335,822
Total FY 2012-13	12,062,031	\$3,766,327
PPA Adjustment		\$12,868
NF-B Adjustment		(\$19,721)
Hospital QAF Adjustment		(\$326,977)
Retro Rate Increase Adjustment		728
<b>Total FY 2012-13</b>		<b>\$3,433,225</b>

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 109

(Dollars in Thousands) <b>FY 2013-14</b>	<b>Eligible Months</b>	<b>Total</b>
San Luis Obispo	340,050	\$93,596
CalOPTIMA(Orange)	766,474	\$211,839
Monterey	745,915	\$345,177
Napa	730,271	\$232,523
San Mateo	416,891	\$127,003
Santa Barbara	4,662,311	\$1,177,275
Santa Cruz	171,992	\$58,934
Solano	905,809	\$230,676
Yolo	326,849	\$107,862
Sonoma	659,473	\$221,900
Merced	890,383	\$186,679
Marin	205,255	\$100,673
Mendocino	243,928	\$71,093
Ventura	1,197,053	\$301,574
<b>Total FY 2013-14</b>	<b>12,262,656</b>	<b>\$3,466,804</b>
PPA Adjustment		\$12,868
NF-B Adjustment		(\$46,362)
CBAS Adjustment		(\$48,844)
<b>Total FY 2013-14</b>		<b>\$3,384,466</b>

**Funding: (In Thousands)****FY 2012-13:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$1,704,624	\$1,704,625	\$3,409,249
State GF	4260-101-0001	\$3,127		\$3,127
Family Planning 90/10 GF	4260-101-0001/0890	\$2,085	\$18,764	\$20,849
<b>Total</b>		<b>\$1,709,836</b>	<b>\$1,723,389</b>	<b>\$3,433,225</b>

**FY 2013-14:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$1,679,916	\$1,679,916	\$3,359,832
State GF	4260-101-0001	\$3,166		\$3,166
Family Planning 90/10 GF	4260-101-0001/0890	\$2,147	\$19,321	\$21,468
<b>Total</b>		<b>\$1,685,229</b>	<b>\$1,699,237</b>	<b>\$3,384,466</b>

## GEOGRAPHIC MANAGED CARE

**BASE POLICY CHANGE NUMBER:** 110  
**IMPLEMENTATION DATE:** 4/1994  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 58

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,216,643,000	\$1,288,011,000
- STATE FUNDS	\$605,815,600	\$641,352,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,216,643,000	\$1,288,011,000
STATE FUNDS	\$605,815,600	\$641,352,200
FEDERAL FUNDS	\$610,827,400	\$646,658,800

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

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

**Reason for Change from Prior Estimate:**

Updated rates were used for the calculations, and the value of potentially preventable admissions, NF-B rate changes, Hospital QAF payments, public hospital IGTs, and retroactive rate increases was accounted for.

**Methodology:**

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

**GEOGRAPHIC MANAGED CARE****BASE POLICY CHANGE NUMBER: 110**

2. The GMC program requires mandatory enrollment for most of Public Assistance, Medically Needy, Medically Indigent Children, Refugee beneficiaries, and Poverty aid codes.
3. The FY 2012-13 and FY 2013-14 rates include:
  - Annual rate redeterminations for FY 2012-13 and FY 2013-14.
  - Pharmacy rate adjustment to exclude avoidable costs
4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the Gross Premium Tax through June 30, 2012. The Administration is proposing legislation to extend the Gross Premium Tax on the total operating revenue for the Medi-Cal Managed Care plans through June 30, 2013. The Administration is also proposing legislation for an MCO tax to apply the statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013.
5. Capitation rate increases due to the Gross Premium Tax and MCO 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 Extend Gross Premium Tax – Funding Adjustment and the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
6. The FY 2012-13 and FY 2013-14 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

(Dollars in Thousands)

<b>FY 2012-13</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento GMC	2,806,034	\$625,728
San Diego GMC	3,352,273	\$799,710
<b>Total FY 2012-13</b>	<b>6,158,601</b>	<b>\$1,425,438</b>
PPA Adjustment		\$2,078
NF-B Adjustment		(\$696)
Public Hospital IGT Adjustment		(\$52,095)
Hospital QAF Adjustment		(\$156,734)
Retro Rate Increase Adjustment		(\$1,348)
<b>Total with Adjustments</b>		<b>\$1,216,643</b>
<b>FY 2013-14</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento GMC	2,856,645	\$612,771
San Diego GMC	3,451,077	\$774,381
<b>Total FY 2013-14</b>	<b>6,307,722</b>	<b>\$1,387,152</b>
PPA Adjustment		\$2,078
NF-B Adjustment		(\$1,636)
Public Hospital IGT Adjustment		(\$26,455)
Hospital QAF Adjustment		(\$73,128)
<b>Total with Adjustments</b>		<b>\$1,288,011</b>

**GEOGRAPHIC MANAGED CARE**

BASE POLICY CHANGE NUMBER: 110

**Funding:**

(Rounded in Thousands)

**FY 2012-13:**

		<u>GF</u>	<u>FF</u>	<u>TF</u>
Title XIX 50/50 FFP	4260-101-0001/0890	\$601,727	\$601,728	\$1,203,455
State GF	4260-101-0001	\$ 3,077	\$ 0	\$ 3,077
Family Planning 90/10 FFP	4260-101-0001/0890	\$ 1,011	\$ 9,100	\$ 10,111
<b>Total</b>		<b>\$605,816</b>	<b>\$610,827</b>	<b>\$1,216,643</b>

**FY 2013-14:**

		<u>GF</u>	<u>FF</u>	<u>TF</u>
Title XIX 50/50 FFP	4260-101-0001/0890	\$ 637,288	\$637,288	\$1,274,576
State GF	4260-101-0001	\$ 3,023	\$ 0	\$ 3,023
Family Planning 90/10 FFP	4260-101-0001/0890	\$ 1,041	\$ 9,371	\$ 10,412
<b>Total</b>		<b>\$ 641,352</b>	<b>\$646,659</b>	<b>\$1,288,011</b>

## PACE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 115  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 62

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$162,892,000	\$220,893,000
- STATE FUNDS	\$81,446,000	\$110,446,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$162,892,000	\$220,893,000
STATE FUNDS	\$81,446,000	\$110,446,500
FEDERAL FUNDS	\$81,446,000	\$110,446,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14591-14593  
Balanced Budget Act of 1997 (BBA)

**Interdependent Policy Changes:**

PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

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

The Department currently has six contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. Four new PACE organizations will begin operation in FY 2013-14. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

## PACE (Other M/C)

### BASE POLICY CHANGE NUMBER: 115

#### Reason for Change from Prior Estimate:

Implementation dates for the new PACE organizations have been delayed due to delays within each PACE organization as well as the withdrawal of the SCAN PACE application.

Below is a list of PACE organizations:

<u>PACE Organization</u>	<u>County</u>	<u>Operational</u>
On Lok Lifeways	San Francisco Alameda Santa Clara	November 1, 1983 July 1, 2002 January 1, 2009
Centers for Elders Independence	Alameda	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
Alta Med Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE- (Community Elder Care of San Diego)	San Diego	February 1, 2008
Cal Optima	Orange	July 1, 2013
Brandman (LA Jewish Home)	Los Angeles	February 1, 2013
InnovAge	San Bernardino	August 1, 2013
Redwood Coast	Humboldt	May 1, 2014
Central Valley Medical Svs.	Fresno	January 1, 2014

#### Methodology:

1. Assume the 2012 and 2013 rates are calculated using the Upper Payment Limit (UPL) for each year. The 2014 rates will be calculated using the existing comparable population UPL methodology.
2. FY 2012-13 estimated funding is based on six-months of calendar year 2012 proposed rates effective January 1, 2012, as well as six-months of calendar year 2013 proposed rates. FY 2013-14 estimated funding is based on calendar year 2013 proposed rates.
3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan and anticipated impact of the CCI demonstration.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 115**

4. The Department anticipates the recoupment of \$7,100,000 from PACE capitation payments paid at calendar year 2009 through 2011 rates. The recoupment began with the January capitation cycle and is expected to be completed by June 2013.
5. The Department anticipates restructuring the methodology to determine the rates beginning in January 2015. The Department expects to achieve savings in FY 2013-14 by transitioning from the UPL-based methodology to an actuarially sound experienced-based methodology.

<b>FY 2012-13</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Average Monthly Enrollment</b>
Center for Elders			
Independence	\$29,489,000	6,760	563
Sutter Senior Care	\$10,063,000	2,675	223
Alta Med Senior BuenaCare	\$58,833,000	15,733	1,311
On Lok Lifeways	\$59,823,000	13,991	1,166
St. Paul's PACE (CESD)	\$11,531,000	3,045	254
Brandman (LAJH)	\$253,000	72	6
<b>Total Capitation Payments</b>	<b>\$169,992,000</b>		
<b>Recoupment</b>	<b>(\$7,100,000)</b>		
<b>Total</b>	<b>\$162,892,000</b>	<b>42,276</b>	<b>3,523</b>
<b>FY 2013-14</b>			
Center for Elders			
Independence	\$34,858,000	7,954	663
Sutter Senior Care	\$11,851,000	3,116	260
Alta Med Senior BuenaCare	\$77,445,000	20,813	1,734
On Lok Lifeways	\$65,856,000	15,368	1,281
St. Paul's PACE (CESD)	\$17,513,000	4,590	383
Brandman (LAJH)	\$2,412,000	678	57
Cal Optima	\$2,272,000	546	46
InnovAge	\$6,671,000	1,602	134
Central Valley Medical Svs.	\$1,827,000	525	44
Redwood Coast	\$188,000	50	4
<b>Total Capitation Payments</b>	<b>\$220,893,000</b>	<b>55,242</b>	<b>4,606</b>

**Funding:**

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

## DENTAL MANAGED CARE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 117  
**IMPLEMENTATION DATE:** 7/2004  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 1029

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$48,887,000	\$48,801,000
- STATE FUNDS	\$24,443,500	\$24,400,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$48,887,000	\$48,801,000
STATE FUNDS	\$24,443,500	\$24,400,500
FEDERAL FUNDS	\$24,443,500	\$24,400,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Social Security Act, Title XIX

**Interdependent Policy Changes:**

PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

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

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

**Reason for Change from Prior Estimate:**

The changes are due to updated monthly eligibles.

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

BASE POLICY CHANGE NUMBER: 117

**Methodology:**

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.
2. The retroactive adjustments of the rates from January 2012 to June 2012 are shown in the Dental Retroactive Rate Changes policy change.
3. Dental rates for the Senior Care Action Network (SCAN) and the Program of All-Inclusive Care for the Elderly (PACE) are incorporated into the SCAN and PACE policy changes.
4. No rate adjustments have been included for FY 2013-14. The prior period rates have been used.

<u>FY 2012-13</u>		<u>Capitation Rate</u>	<u>Average Monthly Eligibles</u>	<u>Total Funds</u>
GMC				
	<21	\$11.46	138,561	\$19,055,000
	21+	\$1.45	78,802	\$1,371,000
PHP				
	<21	\$11.46	196,171	\$26,977,000
	21+	\$1.45	85,260	\$1,484,000
<b>Total</b>				<b>\$48,887,000</b>
<u>FY 2013-14</u>				
GMC				
	<21	\$11.46	140,813	\$19,365,000
	21+	\$1.45	80,083	\$1,393,000
PHP				
	<21	\$11.46	193,285	\$26,581,000
	21+	\$1.45	84,007	\$1,462,000
<b>Total</b>				<b>\$48,801,000</b>

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 118  
**IMPLEMENTATION DATE:** 2/1985  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 61

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$34,873,000	\$24,100,000
- STATE FUNDS	\$17,436,500	\$12,050,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$34,873,000	\$24,100,000
STATE FUNDS	\$17,436,500	\$12,050,000
FEDERAL FUNDS	\$17,436,500	\$12,050,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14200

**Interdependent Policy Changes:**

PC 129 SCAN Transition to Managed Care  
 PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

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

The Department does not plan to renew the SCAN contract. A one-year contract extension for the period of January 1, 2013 through December 31, 2013 has been executed to facilitate transition of SCAN Medi-Cal population to existing Medi-Cal programs. The SCAN Transition to Managed Care policy change budgets the costs associated with the transition of SCAN population into managed care plans.

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

BASE POLICY CHANGE NUMBER: 118

### Reason for Change from Prior Estimate:

The estimated costs have changed due to pending amendments of the 2010-11 and 2012-13 SCAN rates, as well as the recoupment and repayment of capitation payments made using 2009 rates.

### Methodology:

1. Estimated SCAN costs are computed by multiplying the actual and estimated monthly eligible count for each county times the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.
2. Total enrollment is projected to be 7,566 in June 2013 and 7,940 by December 2013 based on Medi-Cal eligibles data submitted by SCAN.
3. The 2010 and 2011 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for 2012 have not been finalized. Therefore, FY 2012-13 and FY 2013-14 rates are based on preliminary rates. Rates in development will be based on SCAN plans' actual experience.
4. AB 1422 (Chapter 157, Statutes of 2009) imposes a gross premium tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax are used to offset the capitation rates. AB 1422 was extended through June 30, 2012. Proposed Trailer Bill Language would extend the tax through June 30, 2013. It would impose the state sales tax rate effective July 1, 2013.
5. Through a departmental medical audit and agreement, individuals who were ineligible for SCAN benefits due to concurrent enrollment in In-Home Supportive Services programs, were allowed to remain enrolled during the periods of May 1, 2008 through December 31, 2008 and January 1, 2009 through December 31, 2009. SCAN will repay the Department for those costs. The Department received the recoupment in the amount of \$20,901,000 in December 2012.
6. The Department anticipates final CMS approval of SCAN 2010-11 rates in April 2013. This will result in a repayment to SCAN of approximately \$8,700,000 for the increase of 2010 Aged/Disabled rates that were paid at 2009 capitated rates. The Department will also recoup approximately \$17,300,000 for decrease to the 2010 Long-Term Care rates that were paid at 2009 capitated rates. This \$17,300,000 recoupment will take place in both FY 2012-13 and FY 2013-14.
7. The Department anticipates final CMS approval and implementation of SCAN 2012-13 rates by June 2013. Subsequently, the Department will repay SCAN approximately \$10,700,000 for capitation payments made using SCAN 2009 rates for period of January 2012 through June 2013.
8. Assume SCAN participants will transition out of SCAN into Coordinated Care Initiative managed care plans beginning January 1, 2014. This transition is shown in the SCAN Transition to Managed Care policy change.

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

BASE POLICY CHANGE NUMBER: 118

	<u>Costs</u>	<u>Eligible Months</u>	<u>Average Monthly Enrollment</u>
<b>FY 2012-13</b>			
Los Angeles	\$25,030,000	57,159	4,763
Riverside	\$7,574,000	18,961	1,580
San Bernardino	\$5,170,000	11,913	993
Total Capitation Payments	<u>\$37,774,000</u>	<u>88,033</u>	<u>7,336</u>
Audit Recoupment	(\$20,901,000)		
2010-11 LTC Rate			
Recoupment	(\$1,400,000)		
2010-11 Aged/Disabled Rate			
Repayment	\$8,700,000		
2012-13 Rate Adjustment	<u>\$10,700,000</u>		
<b>Total</b>	<b>\$34,873,000</b>		
<b>FY 2013-14</b>			
Los Angeles	\$26,589,000	60,720	5,060
Riverside	\$7,969,000	19,951	1,663
San Bernardino	\$5,442,000	12,541	1,045
Total Capitation Payments	<u>\$40,000,000</u>	<u>93,212</u>	<u>7,768</u>
2010-11 LTC Rate			
Recoupment	<u>(\$15,900,000)</u>		
<b>Total</b>	<b>\$24,100,000</b>		

**Funding:**

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

## AIDS HEALTHCARE CENTERS (Other M/C)

**BASE POLICY CHANGE NUMBER:** 119  
**IMPLEMENTATION DATE:** 5/1985  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 63

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$12,381,000	\$12,526,000
- STATE FUNDS	\$6,190,500	\$6,263,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,381,000	\$12,526,000
STATE FUNDS	\$6,190,500	\$6,263,000
FEDERAL FUNDS	\$6,190,500	\$6,263,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14088.85

**Interdependent Policy Changes:**

PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding  
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with the PCCM plan to participate in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department has determined that there are no shared savings for calendar year (CY) 2009, CY 2010, and CY 2011. The shared savings for CY 2012 and beyond have not yet been determined. On January 1, 2012, the Department entered into a new five year contract with AIDS Healthcare Foundation.

AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 has extended the gross premium tax through June 30, 2012. The Administration is proposing legislation to reinstate the Gross Premium Tax.

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

BASE POLICY CHANGE NUMBER: 119

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 MCO Tax to General Fund policy change.

**Reason for Change from Prior Estimate:**

Revised based on updated eligibles. The number of eligibles has decreased between 7% and 16% from the prior estimate.

**Methodology:**

1. Assume in FY 2012-13 dual eligible months will be 4,469 and 4,519 in FY 2013-14.
2. Assume in FY 2012-13 Medi-Cal only eligible months will be 6,069 and 6,141 in FY 2013-14.
3. Dual capitation rates are assumed to be \$272.23 for FY 2012-13 and FY 2013-14.
4. Medi-Cal only capitation rates are assumed to be \$1,839.50 for FY 2012-13 and FY 2013-14.

**Duals:**

FY 12/13:  $4,469 \times \$272.23 = \$1,217,000$

FY 13/14:  $4,519 \times \$272.23 = \$1,230,000$

**Medi-Cal Only:**

FY 11/12:  $6,069 \times \$1,839.50 = \$11,164,000$

FY 12/13:  $6,141 \times \$1,839.50 = \$11,296,000$

	<u>FY 12/13</u>	<u>FY 13/14</u>
Dual	\$ 1,217,000	\$ 1,230,000
Medi-Cal Only	\$11,164,000	\$11,296,000
<b>Total (Rounded)</b>	<b>\$12,381,000</b>	<b>\$12,526,000</b>

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 122  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 66

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,906,000	\$2,915,000
- STATE FUNDS	\$1,453,000	\$1,457,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,906,000	\$2,915,000
STATE FUNDS	\$1,453,000	\$1,457,500
FEDERAL FUNDS	\$1,453,000	\$1,457,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 209 Extend Gross Premium Tax  
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 208 Extend Gross Premium Tax – Funding Adjustment  
 PC 226 MCO Tax Mgd. Care Plans – Incr. Cap. Rates  
 PC 227 MCO Tax Mgd. Care Plans – Funding Adjustment  
 PC 228 MCO Tax Managed Care Plans

**Background:**

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

**Reason for Change from Previous Estimate:**

The contract with the Family Mosaic Project was extended through June 30, 2014 instead of expiring on December 31, 2012.

**Methodology:**

1. It is assumed the member months will be 1,572 for FY 2012-13 and 1,577 for FY 2013-14.
2. The Family Mosaic capitation rates are assumed to be \$1,848.75 for both FY 2012-13 and FY 2013-14.

**FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)****BASE POLICY CHANGE NUMBER: 122**

3. The costs for the Family Mosaic Project are expected to be:

FY 2012-13:  $1,572 \times \$1,848.75 = \mathbf{\$2,906,000}$  TF ( $\mathbf{\$1,453,000}$  GF)

FY 2013-14:  $1,577 \times \$1,848.75 = \mathbf{\$2,915,000}$  TF ( $\mathbf{\$1,457,500}$  GF)

**Funding:**

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

## PERSONAL CARE SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 166  
**IMPLEMENTATION DATE:** 4/1993  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 22

	FY 2012-13	FY 2013-14
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$2,805,292,000</b>	<b>\$2,697,294,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$2,805,292,000</b>	<b>\$2,697,294,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$2,805,292,000</b>	<b>\$2,697,294,000</b>

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreements:

03-75676 (PCSP)

09-86307 (IPO)

SB 1036 (Chapter 45, Statutes of 2012)

SB 1008 (Chapter 33, Statutes of 2012)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

SB 1008 enacted the Coordinated Care Initiative which requires, in part, to mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change Transition of Dual Eligibles-LTC for more information. IHSS costs are currently budgeted in this policy change, but due to the transition of IHSS recipients to managed care, some IHSS costs will be paid through managed care capitation beginning January 1, 2014. IHSS cost related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.

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

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

BASE POLICY CHANGE NUMBER: 166

**Reason for Change from Prior Estimate:**

Updated expenditure data received from CDSS.

**Methodology:****CASH BASIS**

<b>(In Thousands)</b>	<b>TF</b>	<b>FFP</b>	<b>CDSS GF/ County Share</b>
<b>FY 2012-13</b>	\$5,610,584	<b>\$2,805,292</b>	\$2,805,292
<b>FY 2013-14</b>	\$5,394,587	<b>\$2,697,294</b>	\$2,697,294

**Funding:**

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

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

BASE POLICY CHANGE NUMBER: 167  
 IMPLEMENTATION DATE: 7/1988  
 ANALYST: Humei Wang  
 FISCAL REFERENCE NUMBER: 76

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,430,750,000	\$2,563,325,000
- STATE FUNDS	\$1,292,716,500	\$1,365,060,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,430,750,000	\$2,563,325,000
STATE FUNDS	\$1,292,716,500	\$1,365,060,000
FEDERAL FUNDS	\$1,138,033,500	\$1,198,265,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

The premiums have changed:

- For 2013, Part A premium decreased to \$441.00, \$11.00 less than previously estimated; Part B premium increased to \$104.90, \$4.20 less than previously estimated.
- For 2014, Part A premium estimate increases to \$444.90, \$8.10 less than previously estimated; Part B premium estimate increases to \$110.20, \$1.90 less than previously estimated.

**Methodology:**

1. This policy change also includes adjustments due to reconciliations of state and federal data.
2. The Centers for Medicare and Medicaid set the 2012 Medicare Part A premium at \$451.00 and the Medicare Part B premium at \$99.90.
3. The Centers for Medicare and Medicaid set the 2013 premium for Medicare Part A at \$441.00. Medicare Part B premium is set at \$104.90.

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

BASE POLICY CHANGE NUMBER: 167

4. Using the average 2008-2013 premium growth rate 0.88%, the 2014 Medicare Part A premium is estimated to increase by \$3.90 to \$444.90. Based on the 2013 growth rate of 5.01%, 2014 Medicare Part B premium is estimated to increase by \$5.30 to \$110.20.

<b>FY 2012-13</b>	<b>Part A</b>	<b>Part B</b>
Average Monthly Eligibles	171,000	1,175,100
Rate 07/2012-12/2012	\$451.00	\$99.90
Rate 01/2013-06/2013	\$441.00	\$104.90
 <b>FY 2013-14</b>		
Average Monthly Eligibles	174,200	1,204,500
Rate 07/2013-12/2013	\$441.00	\$104.90
Rate 01/2014-06/2014	\$444.90	\$110.20

**Funding:**

State General Fund (4260-101-0001)  
Title XIX 100% FFP (4260-101-0890)

## MEDICARE PAYMENTS - PART D PHASED-DOWN

**BASE POLICY CHANGE NUMBER:** 168  
**IMPLEMENTATION DATE:** 1/2006  
**ANALYST:** Jade Li  
**FISCAL REFERENCE NUMBER:** 1019

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,455,607,000	\$1,481,141,000
- STATE FUNDS	\$1,455,607,000	\$1,481,141,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,455,607,000	\$1,481,141,000
STATE FUNDS	\$1,455,607,000	\$1,481,141,000
FEDERAL FUNDS	\$0	\$0

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreases by 1 2/3% each year until it reaches 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2010	\$102.54
2011	\$100.77
2012	\$102.76
2013	\$103.70
2014	\$98.68 (estimated)

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

BASE POLICY CHANGE NUMBER: 168

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

<u>Fiscal Year</u>	<u>Total Payment</u>	<u>Ave. Monthly Beneficiaries</u>
FY 2009-10	\$864,850,294	1,085,366
FY 2010-11	\$1,049,777,643	1,113,792
FY 2011-12	\$1,367,279,250	1,150,028

**Reason for Change from Prior Estimate:**

- Update 2014 estimated PMPM growth. Prior estimate assumed a 3.31% annual increase, and newly released notice adjusted the growth to -2.76%.
- Update monthly dual eligible Part D enrollment based on later enrollment.

**Methodology:**

1. The growth increase in the Medicare Part D PMPM for calendar year 2012 was 4.10% and Medi-Cal's PMPM increased to \$102.76.
2. The 2013 growth increase is 3.09%, and Medi-Cal's PMPM increased to \$103.70.
3. The 2014 growth is assumed to decrease 2.76% based on the unadjusted 2013 estimated growth change from *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM is expected to decrease to \$98.68.
4. Phase-down payments have a two-month lag. For example, the invoice for the Medi-Cal beneficiaries eligible for Medicare Part D in January 2013 is received in February 2013 and payment is due in March 2013.
5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly dual eligible Part D enrollment data for July 2008– January 2013.
6. The Phased-down Contribution is funded 100% by State General Fund.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
<b>FY 2012-13</b>	12	1,176,839	\$121,300,612	<b>\$1,455,607,000</b>
<b>FY 2013-14</b>	12	1,209,948	\$123,428,413	<b>\$1,481,141,000</b>

**Funding:**

State Only General Fund (4260-101-0001)

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

**BASE POLICY CHANGE NUMBER:** 169  
**IMPLEMENTATION DATE:** 7/1990  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 23

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,065,882,000	\$1,286,515,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,065,882,000	\$1,286,515,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,065,882,000	\$1,286,515,000

**DESCRIPTION****Purpose:**

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

**Authority:**

Interagency Agreement 01-15834

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CDDS, under a federal HCBS waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The HCBS waiver allows the State to offer these services as medical assistance to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services include home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, home and vehicle modifications, prevocational services, skilled nursing, residential services, specialized therapeutic services, and transition/set-up expenses.

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

**Reason for Change from Prior Estimate:**

The estimated amounts for FY 2012-13 and 2013-14 have been revised to reflect updated data.

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

BASE POLICY CHANGE NUMBER: 169

**Methodology:**

1. The following estimates have been provided by CDDS:

(In Thousands)

	<b>Total Funds</b>	<b>CDDS GF</b>	<b>DHCS FFP</b>
<b>FY 2012-13</b>	\$2,131,763	\$1,065,881	<b>\$1,065,882</b>
<b>FY 2013-14</b>	\$2,573,032	\$1,286,516	<b>\$1,286,515</b>

**Funding:**

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

## DENTAL SERVICES

**BASE POLICY CHANGE NUMBER:** 172  
**IMPLEMENTATION DATE:** 7/1988  
**ANALYST:** Randolph Alarcio  
**FISCAL REFERENCE NUMBER:** 135

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$435,640,000	\$506,023,000
- STATE FUNDS	\$213,869,150	\$249,060,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$435,640,000	\$506,023,000
STATE FUNDS	\$213,869,150	\$249,060,650
FEDERAL FUNDS	\$221,770,850	\$256,962,350

### DESCRIPTION

**Purpose:**

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

**Authority:**

Social Security Act, Title XIX

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

Revised based on additional months of actual data and new rates beginning July 2012.

**Methodology:**

1. The capitation rates for FY 2012-13 and FY 2013-14 are \$5.74 for regular eligibles and \$3.22 for refugees.
2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ended June 30, 2011 resulted in an underwriting gain of \$64.3 million. According to contract distribution provisions, the state received \$59.7 million and Delta Dental retained \$4.6 million in FY 2012-13.
3. Full federal funding is available for refugees. The funding adjustment shifting normal state share to 100% federal funds for refugees is aggregated and shown in the Refugee Policy Change.

**Average**

**DENTAL SERVICES**

BASE POLICY CHANGE NUMBER: 172

<b><u>FY 2012-13</u></b>	<b><u>Rate</u></b>	<b><u>Monthly Eligibles</u></b>	<b><u>Total Funds</u></b>
Regular 7/12 – 6/13	\$5.74	6,573,054	\$452,752,000
Refugee 7/12 – 6/13	\$3.22	1,884	\$73,000
Other FFS	Non-Capitated		\$42,515,000
		Subtotal	\$495,340,000
Underwriting Gain			(\$59,700,000)
<b>FY 2012-13 Dental Total</b>			<b>\$435,640,000</b>
<b><u>FY 2013-14</u></b>	<b><u>Rate</u></b>	<b><u>Average Monthly Eligibles</u></b>	<b><u>Total Funds</u></b>
Regular 7/13 – 6/14	\$5.74	6,635,057	\$457,023,000
Refugee 7/13 – 6/14	\$3.22	1,874	\$72,000
Other FFS	Non-Capitated		\$48,928,000
<b>FY 2013-14 Dental Total</b>			<b>\$506,023,000</b>

**Funding:**

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

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

## DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

**BASE POLICY CHANGE NUMBER:** 175  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Jennifer Hsu  
**FISCAL REFERENCE NUMBER:** 77

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$250,517,000	\$236,509,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$250,517,000	\$236,509,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$250,517,000	\$236,509,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOCFs. There are four DCs and one SOCF statewide. The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOCFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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

**Reason for Change from Prior Estimate:**

The changes are due to updated expenditures.

**DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**

BASE POLICY CHANGE NUMBER: 175

**Methodology:**

1. The following estimates have been provided by CDDS.

<b>CASH BASIS</b> (In Thousands)	<b>Total Funds</b>	<b>CDDS GF</b>	<b>FFP Regular</b>	<b>IA #</b>
<b>FY 2012-13</b>	\$501,034	\$250,517	<b>\$250,517</b>	01-15834
<b>FY 2013-14</b>	\$473,018	\$236,509	<b>\$236,509</b>	01-15834

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 176  
**IMPLEMENTATION DATE:** 7/1991  
**ANALYST:** Jennifer Hsu  
**FISCAL REFERENCE NUMBER:** 26

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$145,216,000	\$159,939,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$145,216,000	\$159,939,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$145,216,000	\$159,939,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

Updated caseload.

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

BASE POLICY CHANGE NUMBER: 176

**Methodology:**

1. The following estimates have been provided by CDDS:

<b>CASH BASIS</b> (In Thousands)	<b>Total</b> <b>Funds</b>	<b>CDDS GF</b>	<b>DHCS</b> <b>FFP</b>	<b>IA #</b>
<b>FY 2012-13</b>	\$290,432	\$145,216	<b>\$145,216</b>	03-75284
<b>FY 2013-14</b>	\$319,878	\$159,939	<b>\$159,939</b>	03-75284

**Funding:**

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

## EPSDT SCREENS

**BASE POLICY CHANGE NUMBER:** 177  
**IMPLEMENTATION DATE:** 7/2001  
**ANALYST:** Yumie Park  
**FISCAL REFERENCE NUMBER:** 136

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$36,942,000	\$42,448,000
- STATE FUNDS	\$18,471,000	\$21,224,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$36,942,000	\$42,448,000
STATE FUNDS	\$18,471,000	\$21,224,000
FEDERAL FUNDS	\$18,471,000	\$21,224,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Title 22, California Code of Regulations 51340(a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

Updated data reflected a decrease in the number of screens.

**Methodology:**

Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2012-13 and FY 2013-14, based on a historical trend dating back to July 2007.

**FY 2012-13**

Screens 627,568 x \$58.87 (weighted average) = **\$36,942,000** (rounded)

**FY 2013-14**

Screens 716,881 x \$59.21 (weighted average) = **\$42,448,000** (rounded)

**Funding:**

Title XIX (4260-101-0001/0890)

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

**BASE POLICY CHANGE NUMBER:** 178  
**IMPLEMENTATION DATE:** 6/1995  
**ANALYST:** Yao-Hui Yu  
**FISCAL REFERENCE NUMBER:** 27

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$46,004,000	\$47,845,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$46,004,000	\$47,845,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$46,004,000	\$47,845,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

Updated data became available concerning the TCM expenditures.

**Methodology:**

1. The projected payment amount for FY 2012-13 was based on average expenditures from FY 2007-08 through FY 2011-12 plus an increase of 2% for a rate increase and 2% for cost reconciliation.
2. The projected payment amount for FY 2013-14 was based on the FY 2012-13 estimated amount plus an increase of 2% for a rate increase and 2% for cost reconciliation.

**Funding:**

Title XIX FFP (4260-101-0890)

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

**BASE POLICY CHANGE NUMBER:** 179  
**IMPLEMENTATION DATE:** 4/2000  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 32

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$39,656,000	\$40,674,000
- STATE FUNDS	\$19,828,000	\$20,337,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$39,656,000	\$40,674,000
STATE FUNDS	\$19,828,000	\$20,337,000
FEDERAL FUNDS	\$19,828,000	\$20,337,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

AB 668 (Chapter 896, Statutes of 1998)

**Interdependent Policy Changes:**

PC 25 California Community Transitions Costs

**Background:**

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

**Reason for Change from Prior Estimate:**

The costs for FY 2012-13 have increased due to growth in the average number of WPCS hours used per beneficiary, while the FY 2013-14 costs have decreased based on 5% of California Community Transitions (CCT) beneficiaries expected to use WPCS, instead of 25%.

**WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 179****Methodology:**

1. Assume the number of current NF A/B Level of Care (LOC) Waiver beneficiaries using Waiver PCS is estimated to increase by an average of nine per month in FY 2012-13 and FY 2013-14.
2. Assume the number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by one per month in FY 2012-13 and FY 2013-14.
3. The Department's CCT Demonstration Project expects to transition 365 beneficiaries out of inpatient extended health care facilities during FY 2012-13 and FY 2013-14. Based on actual data, 5% of the beneficiaries are expected to use Waiver PCS.
4. The average cost/hour is \$10.00 for FY 2012-13 and FY 2013-14.

**Funding:**

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

## LAWSUITS/CLAIMS

**BASE POLICY CHANGE NUMBER:** 184  
**IMPLEMENTATION DATE:** 7/1989  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 93

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$4,577,000	\$1,865,000
- STATE FUNDS	\$2,288,500	\$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,577,000	\$1,865,000
STATE FUNDS	\$2,288,500	\$932,500
FEDERAL FUNDS	\$2,288,500	\$932,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

Additional lawsuit settlements.

## LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 184

**Methodology:**

(In Thousands)	<b>Committed 2012-13</b>	<b>Balance 2012-13</b>	<b>Budgeted 2012-13</b>	<b>Budgeted 2013-14</b>
Attorney Fees <\$5,000	\$0	\$50	\$50 *	\$50 *
Provider Settlements <\$75,000	\$483	\$1,117	\$1,600 *	\$1,600 *
Beneficiary Settlements <\$2,000	\$0	\$15	\$15 *	\$15 *
Small Claims Court	\$0	\$200	\$200 *	\$200 *
Other Attorney Fees	\$1,132	N/A	\$1,132	\$0
Other Provider Settlements	\$1,580	N/A	\$1,580	\$0
Other Beneficiary Settlements	\$0	N/A	\$0	\$0
<b>Total</b>	<b>\$3,195</b>	<b>\$1,382</b>	<b>\$4,577</b>	<b>\$1,865</b>

\* Represents potential totals.

**Funding:**

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

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 185  
**IMPLEMENTATION DATE:** 1/1993  
**ANALYST:** Taryn Gerald  
**FISCAL REFERENCE NUMBER:** 91

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,447,000	\$2,255,000
- STATE FUNDS	\$1,223,500	\$1,127,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,447,000	\$2,255,000
STATE FUNDS	\$1,223,500	\$1,127,500
FEDERAL FUNDS	\$1,223,500	\$1,127,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14124.91  
 Social Security Act 1916  
 22 California Code of Regulations 50788

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. The average monthly premium cost is estimated to be \$507.26 in FY 2012-13 and \$466.29 in FY 2013-14.
2. The average monthly HIPP enrollment is estimated to be 402 in FY 2012-13 and 403 in FY 2013-14.

**HIPP PREMIUM PAYOUTS (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 185**

3. Costs for FY 2012-13 and FY 2013-14 are estimated to be:

**FY 2012-13:**  $\$507.26 \times 402 \times 12 \text{ Months} = \$2,447,000 \text{ TF } (\$1,223,500 \text{ GF})$

**FY 2013-14:**  $\$466.29 \times 403 \times 12 \text{ Months} = \$2,255,000 \text{ TF } (\$1,127,500 \text{ GF})$

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 187  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 1083

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,859,000	\$1,285,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,859,000	\$1,285,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,859,000	\$1,285,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA) #07-65689

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The CLPP Program provides case management services utilizing revenues collected from fees. County governments receive the CLPP revenues match with the federal funds for case management services provided to Medi-Cal beneficiaries. The federal match is provided to CDPH through an IA.

**Reason for Change from Prior Estimate:**

The changes are due to delay in contract approval.

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

BASE POLICY CHANGE NUMBER: 187

**Methodology:**

1. Annual expenditures on the accrual basis are \$1,028,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.

(In Thousands)		
<b>FY 2012-13</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<u>\$1,859</u>	<u>\$1,859</u>
<b>FY 2013-14</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<u>\$1,285</u>	<u>\$1,285</u>

**Funding:**

Title XIX FFP (4260-101-0890)

## BASE RECOVERIES

**BASE POLICY CHANGE NUMBER:** 202  
**IMPLEMENTATION DATE:** 7/1987  
**ANALYST:** Celine Donaldson  
**FISCAL REFERENCE NUMBER:** 127

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$294,101,000	-\$251,766,000
- STATE FUNDS	-\$174,451,000	-\$149,340,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$294,101,000	-\$251,766,000
STATE FUNDS	-\$174,451,000	-\$149,340,000
FEDERAL FUNDS	-\$119,650,000	-\$102,426,000

### DESCRIPTION

**Purpose:**

This policy change estimates estates, providers, and other insurance collections used to offset the cost of Medi-Cal services.

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Recoveries credited to the Health Care Deposit Fund finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, providers, and other insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

**Reason for Change from Prior Estimate:**

General Collections growth is due to an increase in provider audits and larger than average estate recoveries. Personal Injury Collections increased in August 2012. The beneficiary shift from Fee-For-Service to Managed Care programs results in lower H.I. Contingency Contract recoveries.

**Methodology:**

1. The recoveries estimate uses the trend in the monthly recoveries for July 2009 – February 2013.
2. The General Fund ratio for collections is estimated to be 59.32% in FY 2012-13 and FY 2013-14.

**BASE RECOVERIES**  
BASE POLICY CHANGE NUMBER: 202

<b>Estimated Base Recoveries</b>	In Thousands	
	<b>FY 2012-13</b>	<b>FY 2013-14</b>
Personal Injury Collections	(\$52,574)	(\$49,535)
Workers' Comp. Contract	(\$2,709)	(\$2,709)
H.I. Contingency Contract	(\$60,000)	(\$60,000)
General Collections	(\$178,818)	(\$139,522)
<b>TOTAL</b>	<b>(\$294,101)</b>	<b>(\$251,766)</b>

**Funding:**

State General Fund (4260-101-0001)

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

## SMHS FOR CHILDREN

**BASE POLICY CHANGE NUMBER:** 224  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1779

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$809,852,000	\$775,685,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$809,852,000	\$775,685,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$809,852,000	\$775,685,000

### DESCRIPTION

**Purpose:**

This policy change estimates the base cost for specialty mental health services (SMHS) provided to children (birth through 20 years of age).

**Authority:**

Welfare & Institutions Code 14680-14685.1  
Specialty Mental Health Consolidation Program Waiver

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking federal reimbursement through claims to the State. MHPs are responsible for the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through managed care (MC) plans (by primary care providers within their scope of practice) or fee-for-service (FFS).

Children’s SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which is available to full-scope beneficiaries under age 21. The EPSDT benefit is designed to meet the special physical, emotional, and developmental needs of low income children. This policy change budgets the costs associated with children’s SMHS. A separate policy change budgets the costs associated with SMHS for Adults.

## SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 224

The following Medi-Cal SMHS are provided for children:

- Adult Residential Treatment Services\*
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services\*
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapeutic Behavioral Services
- Therapy and Other Service Activities

\*Children - Age 18 through 20

Effective July 1, 2012, the administration of Medi-Cal SMHS transferred to the Department from the former Department of Mental Health. The transfer did not impact the service delivery model or services.

### **Reason for Change from Prior Estimate:**

Changes are due to:

- Additional approved claims data,
- The separation of children and adult SMHS into two policy changes, and
- Elimination of the State Maximum Rate (SMA).

### **Methodology:**

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) and Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of March 31, 2013, with dates of service from February 2007 through November 2012. The FFS data is current as of February 28, 2013, with dates of service from January 2007 through October 2012.
2. Due to the lag in reporting of claims data, the most recent six months of data must be weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.

## SMHS FOR CHILDREN

### BASE POLICY CHANGE NUMBER: 224

4. The forecast is based on a service year of costs. This accrual cost is below:

(In Thousands)

	<u>TF</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2010-11	\$1,282,613	\$1,227,300	\$55,314
FY 2011-12	\$1,354,398	\$1,295,542	\$58,856
FY 2012-13	\$1,473,670	\$1,406,850	\$66,820
FY 2013-14	\$1,550,977	\$1,479,893	\$71,084

5. Medi-Cal SMHS program costs are shared between federal funds participation (FFP) and county funds (CF). The accrual costs for FFP and CF are below:

(In Thousands)

	<u>TF</u>	<u>FFP</u>	<u>CF</u>
FY 2010-11	\$1,282,613	\$645,021	\$637,592
FY 2011-12	\$1,354,398	\$681,123	\$673,275
FY 2012-13	\$1,473,670	\$741,117	\$732,553
FY 2013-14	\$1,550,977	\$779,998	\$770,979

6. On a cash basis for FY 2012-13, the Department will be paying 1% of FY 2010-11 claims, 41% of FY 2011-12 claims, and 71% of FY 2012-13 claims for Short-Doyle Medi-Cal claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2010-11 claims, 22% of FY 2011-12 claims, and 78% of FY 2012-13. The overall percentage of Children's SMHS are:

(In Thousands)

	<u>TF</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2010-11	\$12,826	\$12,273	\$553
FY 2011-12	\$544,120	\$531,172	\$12,948
FY 2012-13	<u>\$1,050,983</u>	<u>\$998,864</u>	<u>\$52,120</u>
<b>Total FY 2012-13</b>	<b>\$1,607,929</b>	<b>\$1,542,309</b>	<b>\$65,621</b>

7. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 29% of FY 2012-13 claims, and 71% of FY 2013-14 claims for Short-Doyle Medi-Cal claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2010-11 claims, 22% of FY 2011-12 claims, and 78% of FY 2012-13. The overall percentage of Children's SMHS are:

(In Thousands)

	<u>TF</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2011-12	\$13,544	\$12,955	\$589
FY 2012-13	\$422,687	\$407,987	\$14,700
FY 2013-14	<u>\$1,106,170</u>	<u>\$1,050,724</u>	<u>\$55,445</u>
<b>Total FY 2013-14</b>	<b>\$1,542,400</b>	<b>\$1,471,666</b>	<b>\$70,734</b>

8. Medi-Cal SMHS programs costs are shared between federal funds participation (FFP) and county funds (CF). Medicaid Expansion Children's Health Insurance Program (M-CHIP) claims are eligible for federal reimbursement of 65%. Medi-Cal (MC) claims are eligible for 50% federal reimbursement.

**SMHS FOR CHILDREN**  
**BASE POLICY CHANGE NUMBER: 224**

(In Thousands)

Cash Estimate	<u>TF</u>	<u>FFP</u>	<u>ARRA</u>	<u>M-CHIP*</u>	<u>County</u>
<b>Total FY 2012-13</b>	\$1,607,929	\$788,498	\$1,246	\$20,108	\$798,077

Cash Estimate	<u>TF</u>	<u>FFP</u>	<u>M-CHIP*</u>	<u>County</u>
<b>Total FY 2013-14</b>	\$1,542,400	\$756,252	\$19,433	\$766,715

**Funding:**

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

Title XXI 100% FFP (4260-113-0890)\*

## SMHS FOR ADULTS

**BASE POLICY CHANGE NUMBER:** 225  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 1780

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$541,957,000	\$515,510,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$541,957,000	\$515,510,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$541,957,000	\$515,510,000

### DESCRIPTION

**Purpose:**

This policy change estimates the base cost for specialty mental health services (SMHS) provided to adults (21 years of age and older).

**Authority**

Welfare & Institutions Code 14680-14685.1  
Specialty Mental Health Consolidation Program Waiver

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Medi-Cal SMHS program is “carved-out” of the broader Medi-Cal program and is administered by the Department under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking federal reimbursement through claims to the State. MHPs are responsible for the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through managed care (MC) plans (by primary care providers within their scope of practice) or fee-for-service (FFS).

Children’s SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which is available to full-scope beneficiaries under age 21. A separate policy change budgets the costs associated with SMHS for Children.

## SMHS FOR ADULTS

### BASE POLICY CHANGE NUMBER: 225

The following Medi-Cal SMHS are provided for adults:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapy and Other Service Activities

Effective July 1, 2012, the administration of Medi-Cal SMHS transferred to the Department from the former Department of Mental Health. The transfer did not impact the service delivery model or services.

#### Reason for Change from Prior Estimate:

Changes are due to:

- Additional approved claims data
- The separation of children and adult SMHS into two policy changes, and
- The elimination of the State Maximum Rate (SMA).

#### Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) and Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of March 31, 2013, with dates of service from February 2007 through November 2012. The FFS data is current as of February 28, 2013, with dates of service from January 2007 through October 2012.
2. Due to the lag in reporting of claims data, the six most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. The forecast is based on a service year of costs. This accrual cost is below:

(In Thousands)

	<u>Total</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2010-11	\$882,864	\$762,363	\$120,501
FY 2011-12	\$914,820	\$785,508	\$129,312
FY 2012-13	\$1,003,956	\$860,332	\$143,624
FY 2013-14	\$1,028,520	\$878,142	\$150,378

**SMHS FOR ADULTS**

BASE POLICY CHANGE NUMBER: 225

5. Medi-Cal SMHS program costs are shared between federal funds participation (FFP) and county funds (CF). The accrual cost for FFP and CF are below:

(In Thousands)

	<u>Total</u>	<u>FFP</u>	<u>CF</u>
FY 2010-11	\$882,864	\$441,432	\$441,432
FY 2011-12	\$914,820	\$457,410	\$457,410
FY 2012-13	\$1,003,956	\$501,978	\$501,978
FY 2013-14	\$1,028,520	\$514,260	\$514,260

6. On a cash basis for FY 2012-13, the Department will be paying 1% of FY 2010-11 claims, 41% of FY 2011-12 claims, and 71% of FY 2012-13 claims for Short-Doyle Medi-Cal claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2010-11 claims, 22% of FY 2011-12 claims, and 78% of FY 2012-13. The overall percentage of Adult SMHS are:

(In Thousands)

	<u>Total</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2010-11	\$8,829	\$7,624	\$1,205
FY 2011-12	\$350,507	\$322,058	\$28,449
FY 2012-13	<u>\$722,862</u>	<u>\$610,836</u>	<u>\$112,026</u>
<b>Total FY 2012-13</b>	<b>\$1,082,198</b>	<b>\$940,518</b>	<b>\$141,680</b>

7. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 29% of FY 2012-13 claims, and 71% of FY 2013-14 claims for Short-Doyle Medi-Cal claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2010-11 claims, 22% of FY 2011-12 claims, and 78% of FY 2012-13. The overall percentage of Adult SMHS are:

(In Thousands)

	<u>Total</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2011-12	\$9,148	\$7,855	\$1,293
FY 2012-13	\$281,094	\$249,497	\$31,597
FY 2013-14	<u>\$740,776</u>	<u>\$623,481</u>	<u>\$117,295</u>
<b>Total FY 2013-14</b>	<b>\$1,031,018</b>	<b>\$880,833</b>	<b>\$150,185</b>

8. Medi-Cal (MC) claims are eligible for 50% federal reimbursement.

(In Thousands)

Cash Estimate	<u>TF</u>	<u>FFP</u>	<u>ARRA</u>	<u>County</u>
<b>Total FY 2012-13</b>	<b>\$1,082,198</b>	<b>\$541,100</b>	<b>\$857</b>	<b>\$540,241</b>

Cash Estimate	<u>TF</u>	<u>FFP</u>	<u>County</u>
<b>Total FY 2013-14</b>	<b>\$1,031,018</b>	<b>\$515,510</b>	<b>\$515,508</b>

**Funding:**

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

Title XXI 100% FFP (4260-113-0890)