

### **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 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b><u>DRUG MEDI-CAL</u></b>				
62	NARCOTIC TREATMENT PROGRAM	\$55,944,000	\$55,944,000	\$0
63	RESIDENTIAL TREATMENT SERVICES	\$53,270,000	\$32,254,000	\$21,016,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$27,084,000	\$27,084,000	\$0
65	INTENSIVE OUTPATIENT SERVICES	\$32,160,000	\$24,337,000	\$7,823,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-\$14,650,000	-\$14,650,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$153,808,000</b>	<b>\$124,969,000</b>	<b>\$28,839,000</b>
<b><u>MENTAL HEALTH</u></b>				
69	SMHS FOR CHILDREN	\$728,307,000	\$728,307,000	\$0
70	SMHS FOR ADULTS	\$502,241,000	\$502,241,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,230,548,000</b>	<b>\$1,230,548,000</b>	<b>\$0</b>
<b><u>MANAGED CARE</u></b>				
114	TWO PLAN MODEL	\$7,520,181,000	\$3,776,848,500	\$3,743,332,500
115	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,567,054,000	\$1,789,992,500	\$1,777,061,500
116	GEOGRAPHIC MANAGED CARE	\$1,273,660,000	\$638,930,500	\$634,729,500
122	PACE (Other M/C)	\$196,190,000	\$98,095,000	\$98,095,000
125	DENTAL MANAGED CARE (Other M/C)	\$49,050,000	\$24,525,000	\$24,525,000
126	SENIOR CARE ACTION NETWORK (Other M/C)	\$40,158,000	\$20,079,000	\$20,079,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	\$4,320,000	\$2,160,000	\$2,160,000
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,597,000	\$1,298,500	\$1,298,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$12,653,210,000</b>	<b>\$6,351,929,000</b>	<b>\$6,301,281,000</b>
<b><u>OTHER</u></b>				
171	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,695,250,000	\$2,695,250,000	\$0
172	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,562,827,000	\$1,199,332,500	\$1,363,494,500
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,474,761,000	\$0	\$1,474,761,000
174	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,236,319,000	\$1,236,319,000	\$0
175	DENTAL SERVICES	\$498,146,000	\$259,167,400	\$238,978,600
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$258,500,000	\$258,500,000	\$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$145,524,000	\$145,524,000	\$0
180	MEDI-CAL TCM PROGRAM	\$45,290,000	\$45,290,000	\$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$37,199,000	\$18,599,500	\$18,599,500
182	EPSDT SCREENS	\$38,733,000	\$19,510,800	\$19,222,200
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,446,000	\$1,223,000	\$1,223,000
189	LAWSUITS/CLAIMS	\$2,496,000	\$1,248,000	\$1,248,000
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,799,000	\$1,799,000	\$0
202	BASE RECOVERIES	-\$262,270,000	-\$130,259,000	-\$132,011,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,737,020,000</b>	<b>\$5,751,504,200</b>	<b>\$2,985,515,800</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>
	GRAND TOTAL	<u>\$22,774,586,000</u>	<u>\$13,458,950,200</u>	<u>\$9,315,635,800</u>

## SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b><u>DRUG MEDI-CAL</u></b>				
62	NARCOTIC TREATMENT PROGRAM	\$57,938,000	\$57,938,000	\$0
63	RESIDENTIAL TREATMENT SERVICES	\$128,030,000	\$77,686,000	\$50,344,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$31,226,000	\$31,226,000	\$0
65	INTENSIVE OUTPATIENT SERVICES	\$61,300,000	\$42,653,000	\$18,647,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-\$14,650,000	-\$14,650,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$263,844,000</b>	<b>\$194,853,000</b>	<b>\$68,991,000</b>
<b><u>MENTAL HEALTH</u></b>				
69	SMHS FOR CHILDREN	\$758,674,000	\$758,674,000	\$0
70	SMHS FOR ADULTS	\$512,977,000	\$512,977,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,271,651,000</b>	<b>\$1,271,651,000</b>	<b>\$0</b>
<b><u>MANAGED CARE</u></b>				
114	TWO PLAN MODEL	\$7,847,249,000	\$3,940,491,500	\$3,906,757,500
115	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,607,617,000	\$1,810,502,900	\$1,797,114,100
116	GEOGRAPHIC MANAGED CARE	\$1,357,157,000	\$680,746,000	\$676,411,000
122	PACE (Other M/C)	\$262,614,000	\$131,307,000	\$131,307,000
125	DENTAL MANAGED CARE (Other M/C)	\$49,710,000	\$24,855,000	\$24,855,000
126	SENIOR CARE ACTION NETWORK (Other M/C)	\$39,407,000	\$19,703,500	\$19,703,500
129	AIDS HEALTHCARE CENTERS (Other M/C)	\$9,263,000	\$4,631,500	\$4,631,500
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,708,000	\$1,354,000	\$1,354,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$13,175,725,000</b>	<b>\$6,613,591,400</b>	<b>\$6,562,133,600</b>
<b><u>OTHER</u></b>				
171	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,799,250,000	\$2,799,250,000	\$0
172	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,701,309,000	\$1,262,968,500	\$1,438,340,500
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,453,897,000	\$0	\$1,453,897,000
174	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,297,385,000	\$1,297,385,000	\$0
175	DENTAL SERVICES	\$505,737,000	\$262,962,900	\$242,774,100
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$263,000,000	\$263,000,000	\$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$154,922,000	\$154,922,000	\$0
180	MEDI-CAL TCM PROGRAM	\$44,554,000	\$44,554,000	\$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$37,899,000	\$18,949,500	\$18,949,500
182	EPSDT SCREENS	\$39,279,000	\$19,785,750	\$19,493,250
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,571,000	\$1,285,500	\$1,285,500
189	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$932,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$1,285,000	\$0
202	BASE RECOVERIES	-\$255,248,000	-\$126,771,000	-\$128,477,000
	<b>OTHER SUBTOTAL</b>	<b>\$9,047,705,000</b>	<b>\$6,000,509,650</b>	<b>\$3,047,195,350</b>

**SUMMARY OF BASE POLICY CHANGES  
FISCAL YEAR 2014-15**

<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>\$23,758,925,000</u>	<u>\$14,080,605,050</u>	<u>\$9,678,319,950</u>

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>DRUG MEDI-CAL</b>							
57	NALTREXONE TREATMENT SERVICES	\$0	\$0	\$0	\$0	\$0	\$0
62	NARCOTIC TREATMENT PROGRAM	\$61,500,000	\$0	\$55,944,000	\$0	-\$5,556,000	\$0
63	RESIDENTIAL TREATMENT SERVICES	\$718,000	\$0	\$53,270,000	\$21,016,000	\$52,552,000	\$21,016,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$23,490,000	\$0	\$27,084,000	\$0	\$3,594,000	\$0
65	INTENSIVE OUTPATIENT SERVICES	\$9,563,000	\$0	\$32,160,000	\$7,823,000	\$22,597,000	\$7,823,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	\$0	\$0	-\$14,650,000	\$0	-\$14,650,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$95,271,000</b>	<b>\$0</b>	<b>\$153,808,000</b>	<b>\$28,839,000</b>	<b>\$58,537,000</b>	<b>\$28,839,000</b>
<b>MENTAL HEALTH</b>							
69	SMHS FOR CHILDREN	\$775,685,000	\$0	\$728,307,000	\$0	-\$47,378,000	\$0
70	SMHS FOR ADULTS	\$515,510,000	\$0	\$502,241,000	\$0	-\$13,269,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,291,195,000</b>	<b>\$0</b>	<b>\$1,230,548,000</b>	<b>\$0</b>	<b>-\$60,647,000</b>	<b>\$0</b>
<b>MANAGED CARE</b>							
114	TWO PLAN MODEL	\$7,499,108,000	\$3,734,834,800	\$7,520,181,000	\$3,743,332,500	\$21,073,000	\$8,497,700
115	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,384,466,000	\$1,685,228,800	\$3,567,054,000	\$1,777,061,500	\$182,588,000	\$91,832,700
116	GEOGRAPHIC MANAGED CARE	\$1,288,011,000	\$641,352,200	\$1,273,660,000	\$634,729,500	-\$14,351,000	-\$6,622,700
122	PACE (Other M/C)	\$220,893,000	\$110,446,500	\$196,190,000	\$98,095,000	-\$24,703,000	-\$12,351,500
125	DENTAL MANAGED CARE (Other M/C)	\$48,801,000	\$24,400,500	\$49,050,000	\$24,525,000	\$249,000	\$124,500
126	SENIOR CARE ACTION NETWORK (Other M/C)	\$24,100,000	\$12,050,000	\$40,158,000	\$20,079,000	\$16,058,000	\$8,029,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	\$12,526,000	\$6,263,000	\$4,320,000	\$2,160,000	-\$8,206,000	-\$4,103,000
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,915,000	\$1,457,500	\$2,597,000	\$1,298,500	-\$318,000	-\$159,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$12,480,820,000</b>	<b>\$6,216,033,300</b>	<b>\$12,653,210,000</b>	<b>\$6,301,281,000</b>	<b>\$172,390,000</b>	<b>\$85,247,700</b>
<b>OTHER</b>							
171	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,697,294,000	\$0	\$2,695,250,000	\$0	-\$2,044,000	\$0
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,563,325,000	\$1,365,060,000	\$2,562,827,000	\$1,363,494,500	-\$498,000	-\$1,565,500
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,481,141,000	\$1,481,141,000	\$1,474,761,000	\$1,474,761,000	-\$6,380,000	-\$6,380,000
174	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,286,515,000	\$0	\$1,236,319,000	\$0	-\$50,196,000	\$0
175	DENTAL SERVICES	\$506,023,000	\$249,060,650	\$498,146,000	\$238,978,600	-\$7,877,000	-\$10,082,050
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$236,509,000	\$0	\$258,500,000	\$0	\$21,991,000	\$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$159,939,000	\$0	\$145,524,000	\$0	-\$14,415,000	\$0

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER</b>							
180	MEDI-CAL TCM PROGRAM	\$47,845,000	\$0	\$45,290,000	\$0	-\$2,555,000	\$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,674,000	\$20,337,000	\$37,199,000	\$18,599,500	-\$3,475,000	-\$1,737,500
182	EPSDT SCREENS	\$42,448,000	\$21,224,000	\$38,733,000	\$19,222,200	-\$3,715,000	-\$2,001,800
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,255,000	\$1,127,500	\$2,446,000	\$1,223,000	\$191,000	\$95,500
189	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$2,496,000	\$1,248,000	\$631,000	\$315,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$0	\$1,799,000	\$0	\$514,000	\$0
202	BASE RECOVERIES	-\$251,766,000	-\$149,340,000	-\$262,270,000	-\$132,011,000	-\$10,504,000	\$17,329,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,815,352,000</b>	<b>\$2,989,542,650</b>	<b>\$8,737,020,000</b>	<b>\$2,985,515,800</b>	<b>-\$78,332,000</b>	<b>-\$4,026,850</b>
	<b>GRAND TOTAL</b>	<b>\$22,682,638,000</b>	<b>\$9,205,575,950</b>	<b>\$22,774,586,000</b>	<b>\$9,315,635,800</b>	<b>\$91,948,000</b>	<b>\$110,059,850</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2013-14 AND 2014-15**

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>DRUG MEDI-CAL</b>							
62	NARCOTIC TREATMENT PROGRAM	\$55,944,000	\$0	\$57,938,000	\$0	\$1,994,000	\$0
63	RESIDENTIAL TREATMENT SERVICES	\$53,270,000	\$21,016,000	\$128,030,000	\$50,344,000	\$74,760,000	\$29,328,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$27,084,000	\$0	\$31,226,000	\$0	\$4,142,000	\$0
65	INTENSIVE OUTPATIENT SERVICES	\$32,160,000	\$7,823,000	\$61,300,000	\$18,647,000	\$29,140,000	\$10,824,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-\$14,650,000	\$0	-\$14,650,000	\$0	\$0	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$153,808,000</b>	<b>\$28,839,000</b>	<b>\$263,844,000</b>	<b>\$68,991,000</b>	<b>\$110,036,000</b>	<b>\$40,152,000</b>
<b>MENTAL HEALTH</b>							
69	SMHS FOR CHILDREN	\$728,307,000	\$0	\$758,674,000	\$0	\$30,367,000	\$0
70	SMHS FOR ADULTS	\$502,241,000	\$0	\$512,977,000	\$0	\$10,736,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,230,548,000</b>	<b>\$0</b>	<b>\$1,271,651,000</b>	<b>\$0</b>	<b>\$41,103,000</b>	<b>\$0</b>
<b>MANAGED CARE</b>							
114	TWO PLAN MODEL	\$7,520,181,000	\$3,743,332,500	\$7,847,249,000	\$3,906,757,500	\$327,068,000	\$163,425,000
115	COUNTY ORGANIZED HEALTH SYSTEMS	\$3,567,054,000	\$1,777,061,500	\$3,607,617,000	\$1,797,114,100	\$40,563,000	\$20,052,600
116	GEOGRAPHIC MANAGED CARE	\$1,273,660,000	\$634,729,500	\$1,357,157,000	\$676,411,000	\$83,497,000	\$41,681,500
122	PACE (Other M/C)	\$196,190,000	\$98,095,000	\$262,614,000	\$131,307,000	\$66,424,000	\$33,212,000
125	DENTAL MANAGED CARE (Other M/C)	\$49,050,000	\$24,525,000	\$49,710,000	\$24,855,000	\$660,000	\$330,000
126	SENIOR CARE ACTION NETWORK (Other M/C)	\$40,158,000	\$20,079,000	\$39,407,000	\$19,703,500	-\$751,000	-\$375,500
129	AIDS HEALTHCARE CENTERS (Other M/C)	\$4,320,000	\$2,160,000	\$9,263,000	\$4,631,500	\$4,943,000	\$2,471,500
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$2,597,000	\$1,298,500	\$2,708,000	\$1,354,000	\$111,000	\$55,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$12,653,210,000</b>	<b>\$6,301,281,000</b>	<b>\$13,175,725,000</b>	<b>\$6,562,133,600</b>	<b>\$522,515,000</b>	<b>\$260,852,600</b>
<b>OTHER</b>							
171	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,695,250,000	\$0	\$2,799,250,000	\$0	\$104,000,000	\$0
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,562,827,000	\$1,363,494,500	\$2,701,309,000	\$1,438,340,500	\$138,482,000	\$74,846,000
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,474,761,000	\$1,474,761,000	\$1,453,897,000	\$1,453,897,000	-\$20,864,000	-\$20,864,000
174	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)	\$1,236,319,000	\$0	\$1,297,385,000	\$0	\$61,066,000	\$0
175	DENTAL SERVICES	\$498,146,000	\$238,978,600	\$505,737,000	\$242,774,100	\$7,591,000	\$3,795,500
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$258,500,000	\$0	\$263,000,000	\$0	\$4,500,000	\$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 2013-14 AND 2014-15**

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>OTHER</b>						
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$145,524,000	\$0	\$154,922,000	\$0	\$9,398,000	\$0
180	MEDI-CAL TCM PROGRAM	\$45,290,000	\$0	\$44,554,000	\$0	-\$736,000	\$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$37,199,000	\$18,599,500	\$37,899,000	\$18,949,500	\$700,000	\$350,000
182	EPSDT SCREENS	\$38,733,000	\$19,222,200	\$39,279,000	\$19,493,250	\$546,000	\$271,050
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,446,000	\$1,223,000	\$2,571,000	\$1,285,500	\$125,000	\$62,500
189	LAWSUITS/CLAIMS	\$2,496,000	\$1,248,000	\$1,865,000	\$932,500	-\$631,000	-\$315,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,799,000	\$0	\$1,285,000	\$0	-\$514,000	\$0
202	BASE RECOVERIES	-\$262,270,000	-\$132,011,000	-\$255,248,000	-\$128,477,000	\$7,022,000	\$3,534,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,737,020,000</b>	<b>\$2,985,515,800</b>	<b>\$9,047,705,000</b>	<b>\$3,047,195,350</b>	<b>\$310,685,000</b>	<b>\$61,679,550</b>
	<b>GRAND TOTAL</b>	<b>\$22,774,586,000</b>	<b>\$9,315,635,800</b>	<b>\$23,758,925,000</b>	<b>\$9,678,319,950</b>	<b>\$984,339,000</b>	<b>\$362,684,150</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>	
62	NARCOTIC TREATMENT PROGRAM
63	RESIDENTIAL TREATMENT SERVICES
64	OUTPATIENT DRUG FREE TREATMENT SERVICES
65	INTENSIVE OUTPATIENT SERVICES
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM
<b><u>MENTAL HEALTH</u></b>	
69	SMHS FOR CHILDREN
70	SMHS FOR ADULTS
<b><u>MANAGED CARE</u></b>	
114	TWO PLAN MODEL
115	COUNTY ORGANIZED HEALTH SYSTEMS
116	GEOGRAPHIC MANAGED CARE
122	PACE (Other M/C)
125	DENTAL MANAGED CARE (Other M/C)
126	SENIOR CARE ACTION NETWORK (Other M/C)
129	AIDS HEALTHCARE CENTERS (Other M/C)
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
<b><u>OTHER</u></b>	
171	PERSONAL CARE SERVICES (Misc. Svcs.)
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
173	MEDICARE PAYMENTS - PART D PHASED-DOWN
174	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)
175	DENTAL SERVICES
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
180	MEDI-CAL TCM PROGRAM
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
182	EPSDT SCREENS
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
189	LAWSUITS/CLAIMS
190	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:** 62  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1728

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$55,944,000	\$57,938,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$55,944,000	\$57,938,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$55,944,000	\$57,938,000

### 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)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The NTP provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

Currently, the DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Effective July 1, 2011, the funds to cover the non-federal share of cost were realigned to counties as County Funds (CF). Funding for the services is 50% county funds and 50% Title XIX federal funds. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this mandatory and optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon those without health coverage. These mandatory requirements will likely encourage many individuals who are currently eligible but not enrolled in Medi-Cal to enroll in the program.

The mandatory expansion population refers to the population who is currently eligible for Medi-Cal but is

## NARCOTIC TREATMENT PROGRAM

### BASE POLICY CHANGE NUMBER: 62

not enrolled. This population is expected to enroll and access Medi-Cal services starting January 1, 2014. For this population's services, County Funds (CF) will be used to match federal funds. Funding for the services is 50% CF and 50% Title XIX federal funds.

The optional expansion population is currently not eligible for Medi-Cal but will become eligible for Medi-Cal starting January 1, 2014. This population is expected to enroll and access Medi-Cal services starting January 1, 2014. Funding for the services is 100% Title XIX federal funds.

For the November 2013 Estimate, the DMC program changed the methodology used to compute average annual caseload. In prior years, the annual caseload was based on the sum of the four quarters of CalOMS caseload data. Presently, the program uses actual DMC billing data to determine unique client caseload. In addition, caseload is now based on 36 months of recent data instead of the 20 quarters previously used.

For FY 2014-15, the DMC reimbursement rate will be adjusted to eliminate the 10% county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. The county administration costs will be paid under a quarterly invoicing process. The county administration costs can be found in the policy change titled DMC County Admin.

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

- Beginning January 2014, the NTP services will be expanded to additional newly eligible Medi-Cal beneficiaries as a result of the ACA expansion.
- The new caseload methodology reduced the caseload projections for the current population.

#### **Methodology:**

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for DMC beginning January 2014. Additional caseload data for the expanded eligibles was developed for mandatory and optional populations expected to access this service in January 2014.
5. Assume the caseload projection for the optional expansion population is 1,163 for FY 2013-14 and 2,739 for FY 2014-15.
6. Assume the caseload projection for the mandatory expansion population is 164 for FY 2013-14 and 642 for FY 2014-15.
7. The Units of Service (UOS) is based on the most recent complete data, July 2011-June 2012 to calculate an average UOS.
8. 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

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

<b>Narcotic Treatment</b>	<b>FY 2009-10 UOS Rate</b>	<b>CIP Deflator</b>	<b>FY 2013-14 Rates*</b>	<b>FY 2013-14 Developed Rates</b>	<b>FY 2013-14 Required Rates</b>
Regular					
Dosing	\$11.34	8.7%	\$12.33	\$11.49	\$11.49
Individual	\$13.30	8.7%	\$14.46	\$15.42	\$14.46
Group	\$3.14	8.7%	\$3.41	\$3.27	\$3.27
Perinatal					
Dosing	\$12.21	8.7%	\$13.27	\$12.57	\$12.57
Individual	\$19.04	8.7%	\$20.70	\$24.08	\$20.70
Group	\$6.36	8.7%	\$6.91	\$7.41	\$6.91

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

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

**FY 2013-14**

	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current Population</b>				
<b>Regular</b>				
Dosing	74,592	77.2	\$11.49	\$66,165,193
Individual	74,592	36.2	\$14.46	\$39,045,332
Group	74,592	0.2	\$3.27	\$48,783
Total				\$105,259,307
<b>EPSDT</b>				
Dosing	694	56.5	\$11.49	\$450,534
Individual	694	28.6	\$14.46	\$287,008
Group	694	0.1	\$3.27	\$227
Total				\$737,769
<b>Minor Consent</b>				
Dosing	10	115	\$11.49	\$13,214
Individual	10	69.4	\$14.46	\$10,035
Group	10	0	\$3.27	\$0
Total				\$23,249
<b>Perinatal</b>				
Dosing	170	53.1	\$12.57	\$113,469
Individual	170	18.1	\$20.70	\$63,694
Group	170	1	\$6.91	\$1,175
Total				\$178,338

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

<b>Mandatory</b>				
<b>Regular</b>				
Dosing	161	77.2	\$11.49	\$142,812
Individual	161	36.2	\$14.46	\$84,276
Group	161	0.2	\$3.27	\$105
Total				<u>\$227,193</u>
<b>EPSDT</b>				
Dosing	2	56.5	\$11.49	\$1,298
Individual	2	28.6	\$14.46	\$827
Group	2	0.1	\$3.27	\$1
Total				<u>\$2,126</u>
<b>Minor Consent</b>				
Dosing	-	115	\$11.49	\$0
Individual	-	69.4	\$14.46	\$0
Group	-	0	\$3.27	\$0
Total				<u>\$0</u>
<b>Perinatal</b>				
Dosing	1	53.1	\$12.57	\$667
Individual	1	18.1	\$20.70	\$375
Group	1	1	\$6.91	\$7
Total				<u>\$1,049</u>
<b>Optional</b>				
<b>Regular</b>				
Dosing	1,147	77.2	\$11.49	\$1,017,421
Individual	1,147	36.2	\$14.46	\$600,399
Group	1,147	0.2	\$3.27	\$750
Total				<u>\$1,618,571</u>
<b>EPSDT</b>				
Dosing	11	56.5	\$11.49	\$7,141
Individual	11	28.6	\$14.46	\$4,549
Group	11	0.1	\$3.27	\$4
Total				<u>\$11,694</u>
<b>Minor Consent</b>				
Dosing	-	115	\$11.49	\$0
Individual	-	69.4	\$14.46	\$0
Group	-	0	\$3.27	\$0
Total				<u>\$0</u>
<b>Perinatal</b>				
Dosing	5	53.1	\$12.57	\$3,337
Individual	5	18.1	\$20.70	\$1,873
Group	5	1.0	\$6.91	\$35
Total				<u>\$5,245</u>

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

**FY 2014-15**

	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
<b>Current Population</b>				
<b>Regular</b>				
Dosing	76,608	77.2	\$11.49	\$67,953,441
Individual	76,608	36.2	\$14.46	\$40,100,611
Group	76,608	0.2	\$3.27	\$50,102
Total				\$108,104,153
<b>EPSDT</b>				
Dosing	702	56.5	\$11.49	\$455,728
Individual	702	28.6	\$14.46	\$290,316
Group	702	0.1	\$3.27	\$230
Total				\$746,274
<b>Minor Consent</b>				
Dosing	0	115	\$11.49	\$0
Individual	0	69.4	\$14.46	\$0
Group	0	0	\$3.27	\$0
Total				\$0
<b>Perinatal</b>				
Dosing	101	53.1	\$12.57	\$67,414
Individual	101	18.1	\$20.70	\$37,842
Group	101	1	\$6.91	\$698
Total				\$105,954
<b>Mandatory</b>				
<b>Regular</b>				
Dosing	634	77.2	\$11.49	\$562,376
Individual	634	36.2	\$14.46	\$331,869
Group	634	0.2	\$3.27	\$415
Total				\$894,659
<b>EPSDT</b>				
Dosing	6	56.5	\$11.49	\$3,895
Individual	6	28.6	\$14.46	\$2,481
Group	6	0.1	\$3.27	\$2
Total				\$6,378
<b>Minor Consent</b>				
Dosing	0	115	\$11.49	\$0
Individual	0	69.4	\$14.46	\$0
Group	0	0	\$3.27	\$0
Total				\$0
<b>Perinatal</b>				
Dosing	2	53.1	\$12.57	\$1,335
Individual	2	18.1	\$20.70	\$749
Group	2	1	\$6.91	\$14
Total				\$2,098

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

<b>Optional</b>				
<b>Regular</b>				
Dosing	2,701	77.2	\$11.49	\$2,395,863
Individual	2,701	36.2	\$14.46	\$1,413,844
Group	2,701	0.2	\$3.27	\$1,766
Total				\$3,811,473
<b>EPSDT</b>				
Dosing	26	56.5	\$11.49	\$16,879
Individual	26	28.6	\$14.46	\$10,752
Group	26	0.1	\$3.27	\$9
Total				\$27,640
<b>Minor Consent</b>				
Dosing	1	115	\$11.49	\$1,321
Individual	1	69.4	\$14.46	\$1,004
Group	1	0	\$3.27	\$0
Total				\$2,325
<b>Perinatal</b>				
Dosing	11	53.1	\$12.57	\$7,342
Individual	11	18.1	\$20.70	\$4,121
Group	11	1	\$6.91	\$76
Total				\$11,540

10. 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.

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
Regular	\$116,850,000	\$29,213,000	\$0
Minor Consent	\$82,000	\$20,000	\$0
Perinatal	\$395,000	\$99,000	\$0
<b>FY 2012-13</b>	<b>\$117,327,000</b>	<b>\$29,332,000</b>	<b>\$0</b>
<b>Current</b>			
Regular	\$105,997,077	\$79,497,807	\$26,499,269
Minor Consent	\$23,249	\$17,437	\$5,812
Perinatal	\$178,338	\$133,753	\$44,584
<b>Mandatory</b>			
Regular	\$229,319	\$171,989	\$57,330
Minor Consent	\$0	\$0	\$0
Perinatal	\$1,049	\$787	\$262
<b>Optional</b>			
Regular	\$1,630,264	\$1,222,698	\$407,566
Minor Consent	\$0	\$0	\$0
Perinatal	\$5,245	\$3,934	\$1,311
<b>FY 2013-14</b>	<b>\$108,064,541</b>	<b>\$81,048,406</b>	<b>\$27,016,135</b>

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

<b>Current</b>			
Regular	\$108,850,427	\$0	\$81,637,820
Minor Consent	\$0	\$0	\$0
Perinatal	\$105,954	\$0	\$79,465
<b>Mandatory</b>			
Regular	\$901,037	\$0	\$675,778
Minor Consent	\$0	\$0	\$0
Perinatal	\$2,098		\$1,574
<b>Optional</b>			
Regular	\$3,839,113	\$0	\$2,879,335
Minor Consent	\$2,325	\$0	\$1,744
Perinatal	\$11,540	\$0	\$8,655
<b>FY 2014-15</b>	<b>\$113,712,494</b>	<b>\$0</b>	<b>\$85,284,370</b>

11. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consent costs are funded by the counties. Newly eligible beneficiaries in the expanded and mandatory categories are funded 50% CF and 50% FFP. Beneficiaries in the optional category are funded 100% FFP.

<u>FY 2013-14</u>	<u>TF</u>	<u>FF (Title XIX)</u>	<u>FF (Title XXI)</u>	<u>County</u>	<u>GF</u>
<b>Current</b>					
Regular	\$107,884,605	\$53,942,303	\$0	\$53,942,303	\$0
Minor Consent	\$37,437	\$0	\$0	\$37,437	\$0
Perinatal (Title XIX)	\$4,899	\$3,185	\$0	\$1,715	\$0
Regular (Title XXI)	\$826,202	\$0	\$537,031	\$289,171	\$0
Perinatal (Title XXI)	\$227,854	\$0	\$148,105	\$79,749	\$0
<b>Mandatory</b>					
Regular	\$170,682	\$85,341	\$0	\$85,341	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$17	\$11	\$0	\$6	\$0
Regular (Title XXI)	\$1,307	\$0	\$850	\$457	\$0
Perinatal (Title XXI)	\$770	\$0	\$501	\$270	\$0
<b>Optional</b>					
Regular	\$1,213,406	\$1,213,406	\$0	\$0	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$83	\$83	\$0	\$0	\$0
Regular (Title XXI)	\$9,293	\$0	\$9,293	\$0	\$0
Perinatal (Title XXI)	\$3,851	\$0	\$3,851	\$0	\$0
<b>Total FY 2013-14</b>	<b>\$110,380,406</b>	<b>\$55,244,328</b>	<b>\$699,630</b>	<b>\$54,436,447</b>	<b>\$0</b>

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 62**

<b>FY 2014-15</b>	<b>TF</b>	<b>FF (Title XIX)</b>	<b>FF (Title XXI)</b>	<b>County</b>	<b>GF</b>
<b>Current</b>					
Regular	\$107,315,248	\$53,657,624	\$0	\$53,657,624	\$0
Minor Consent	\$5,812	\$0	\$0	\$5,812	\$0
Perinatal (Title XIX)	\$2,611	\$1,697	\$0	\$914	\$0
Regular (Title XXI)	\$821,842	\$0	\$534,197	\$287,645	\$0
Perinatal (Title XXI)	\$121,439	\$0	\$78,935	\$42,503	\$0
<b>Mandatory</b>					
Regular	\$727,536	\$363,768	\$0	\$363,768	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$39	\$25	\$0	\$14	\$0
Regular (Title XXI)	\$5,572	\$0	\$3,622	\$1,950	\$0
Perinatal (Title XXI)	\$1,797	\$0	\$1,168	\$629	\$0
<b>Optional</b>					
Regular	\$3,261,920	\$3,261,920	\$0	\$0	\$0
Minor Consent	\$1,744	\$0	\$0	\$1,744	\$0
Perinatal (Title XIX)	\$210	\$210	\$0	\$0	\$0
Regular (Title XXI)	\$24,980	\$0	\$24,980	\$0	\$0
Perinatal (Title XXI)	\$9,756	\$0	\$9,756	\$0	\$0
<b>Total FY 2014-15</b>	<b>\$112,300,505</b>	<b>\$57,285,244</b>	<b>\$652,659</b>	<b>\$54,362,602</b>	<b>\$0</b>

**Funding:**

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

100% Title XIX (4260-101-0890)

## RESIDENTIAL TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 63  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1725

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$53,270,000	\$128,030,000
- STATE FUNDS	\$21,016,000	\$50,344,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$53,270,000	\$128,030,000
STATE FUNDS	\$21,016,000	\$50,344,000
FEDERAL FUNDS	\$32,254,000	\$77,686,000

### DESCRIPTION

**Purpose:**

This policy change estimates the reimbursement for the Drug Medi-Cal (DMC) Residential Treatment Service.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(17); 51341.1 (d)(4); 51516.1 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Residential Treatment Service provides rehabilitation services to beneficiaries with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in effort 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:

- 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.

Currently, the DMC program provides certain medically necessary substance use treatment services.

## RESIDENTIAL TREATMENT SERVICES

### BASE POLICY CHANGE NUMBER: 63

These services are provided by certified providers under contract with the counties or with the State. Effective July 1, 2011, the funds to cover the non-federal share of cost were realigned to counties as County Funds (CF). Funding for the services is 50% county funds and 50% Title XIX federal funds. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this expanded, mandatory, and optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon those without health coverage. These mandatory requirements will likely encourage many individuals who are currently eligible but not enrolled in Medi-Cal to enroll in the program.

The mandatory expansion population refers to the population who is currently eligible for Medi-Cal but is not enrolled in Medi-Cal. This population is expected to enroll and access Medi-Cal services starting January 1, 2014. For this population's services, county funds will not be used to match federal funds. Instead, General Funds (GF) will be used to match federal funds. Funding for the services is 50% GF and 50% Title XIX federal funds.

The expanded population refers to the population who is eligible and enrolled in Medi-Cal now, but are not receiving this service because it is currently not available to them. This population is expected to enroll in Medi-Cal and access this service starting January 1, 2014. Funding for the services is 50% GF and 50% Title XIX federal funds.

The mandatory expansion population refers to the population who is currently eligible for Medi-Cal but is not enrolled. This population is expected to enroll and access Medi-Cal services starting January 1, 2014. For this population's services, General Funds (GF) will be used to match federal funds. Funding for the services is 50% GF and 50% Title XIX federal funds.

The optional expansion population is currently not eligible for Medi-Cal but will become eligible for Medi-Cal starting January 1, 2014. This population is expected to enroll access Medi-Cal services starting January 1, 2014. Funding for the services is 100% Title XIX federal funds.

For the November 2013 Estimate, the DMC program changed the methodology used to compute average annual caseload. In prior years, the annual caseload was based on the sum of the four quarters of CalOMS caseload data. Presently, the program uses actual DMC billing data to determine unique client caseload. In addition, caseload is now based on 36 months of recent data instead of the 20 quarters previously used.

For FY 2014-15, the DMC reimbursement rate will be adjusted to eliminate the 10% county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. The county administration costs will be paid under a quarterly invoicing process. The county administration costs can be found in the policy change titled DMC County Admin.

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

- Beginning January 2014, the Residential Treatment Service will be expanded to additional newly eligible Medi-Cal beneficiaries as a result of the ACA expansion.
- The new caseload methodology reduced the caseload for the current Residential Treatment Service population.

## RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 63

### Methodology:

1. The DMC eligible clients are categorized into Regular and Perinatal.
2. DMC program administration assumes the federal Centers for Medicare and Medicaid Services (CMS) will approve its request to use the existing Perinatal Residential reimbursement rate for both the Perinatal and Non-Perinatal Residential services until FY 2017-18 when FY 2013-14 cost data will be available to produce a new cost-driven non-Perinatal residential rate.
3. The caseload projections are based on 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for DMC beginning January 2014. Additional caseload data was developed for the expanded, mandatory, and optional populations expected to access this service in January 2014.
5. Assume the caseload projection for the expanded population is 9,905 for FY 2013-14 (based on 6 months, January through June 2014) and 19,810 for FY 2014-15.
6. Assume the caseload projection for the mandatory expansion population is 262 for FY 2013-14 (based on 6 months, January through June 2014) and 1,026 for FY 2014-15.
7. Assume the caseload projection for the optional expansion population is 1,860 for FY 2013-14 (based on 6 months, January through June 2014) and 4,379 for FY 2014-15.
8. The Units of Service (UOS) is based on the most recent complete data, July 2011-June 2012 to calculate an average UOS for existing caseload.
9. 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 2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

<b>Description</b>	<b>FY 2009-10 UOS Rate</b>	<b>CIP Deflator</b>	<b>FY 2013-14 Rates*</b>	<b>FY 2013-14 Developed Rates</b>	<b>FY 2013-14 Required Rates</b>
Residential	\$89.90	8.7%	\$97.72	\$110.29	\$97.72

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

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

<b>FY 2013-14</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current</b>				
Perinatal	297	60.5	\$98	\$1,755,882
<b>Expanded Population</b>				
Regular	9,306	60.5	\$98	\$55,017,630

**RESIDENTIAL TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 63

Minor Consent	27	60.5	\$98	\$159,626
Perinatal	572	60.5	\$98	\$3,381,698
Total				\$58,558,954
<b>Mandatory Population</b>				
Regular	246	60.5	\$98	\$1,454,367
Minor Consent	1	60.5	\$98	\$5,912
Perinatal	15	60.5	\$98	\$88,681
Total				\$1,548,960
<b>Optional Population</b>				
Regular	1,748	60.5	\$98	\$10,334,281
Minor Consent	5	60.5	\$98	\$29,560
Perinatal	107	60.5	\$98	\$632,590
Total				\$10,996,432
<b>FY 2014-15</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current</b>				
Perinatal	246	60.5	\$98	\$1,454,367
<b>Expanded Population</b>				
Regular	18,612	60.5	\$98	\$110,035,261
Minor Consent	55	60.5	\$98	\$325,163
Perinatal	1,143	60.5	\$98	\$6,757,485
Total				\$117,117,909
<b>Mandatory Population</b>				
Regular	964	60.5	\$98	\$5,699,226
Minor Consent	2	60.5	\$98	\$11,824
Perinatal	60	60.5	\$98	\$354,724
Total				\$6,065,774
<b>Optional Population</b>				
Regular	4,114	60.5	\$98	\$24,322,215
Minor Consent	12	60.5	\$98	\$70,945
Perinatal	253	60.5	\$98	\$1,495,751
Total				\$25,888,911

11. 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.

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
Perinatal	\$1,578,000	\$394,000	
FY 2012-13	\$1,578,000	\$394,000	\$0
<b>Current</b>			
Perinatal	\$1,755,882	\$1,316,911	\$438,970
<b>Expansion</b>			
Regular	\$55,017,630	\$41,263,223	\$13,754,408

**RESIDENTIAL TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 63

Minor Consent	\$159,626	\$119,719	\$39,906
Perinatal	\$3,381,698	\$2,536,274	\$845,425
<b>Mandatory</b>			
Regular	\$1,454,367	\$1,090,775	\$363,592
Minor Consent	\$5,912	\$4,434	\$1,478
Perinatal	\$88,681	\$66,511	\$22,170
<b>Optional</b>			
Regular	\$10,334,281	\$7,750,711	\$2,583,570
Minor Consent	\$29,560	\$22,170	\$7,390
Perinatal	\$632,590	\$474,443	\$158,148
<b>FY 2013-14</b>	<b>\$72,860,227</b>	<b>\$54,645,171</b>	<b>\$18,215,057</b>
<b>Current</b>			
Perinatal	\$1,454,367	\$0	\$1,090,775
<b>Expansion</b>			
Regular	\$110,035,261	\$0	\$82,526,446
Minor Consent	\$325,163	\$0	\$243,872
Perinatal	\$6,757,485	\$0	\$5,068,113
<b>Mandatory</b>			
Regular	\$5,699,226	\$0	\$4,274,419
Minor Consent	\$11,824	\$0	\$8,868
Perinatal	\$354,724	\$0	\$266,043
<b>Optional</b>			
Regular	\$24,322,215	\$0	\$18,241,661
Minor Consent	\$70,945	\$0	\$53,209
Perinatal	\$1,495,751	\$0	\$1,121,813
<b>FY 2014-15</b>	<b>\$150,526,960</b>	<b>\$0</b>	<b>\$112,895,220</b>

12. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consents costs are funded by the counties. Newly eligible beneficiaries in the expanded and mandatory categories are funded 50% GF and 50% FFP. Beneficiaries in the optional category are funded 100% FFP.

<u>FY 2013-14</u>	<u>TF</u>	<u>FF Title XIX</u>	<u>FF Title XXI</u>	<u>CF</u>	<u>GF</u>
<b>Current</b>					
Regular	\$0	\$0	\$0	\$0	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$36,015	\$23,410	\$0	\$12,605	\$0
Regular (Title XXI)	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XXI)	\$1,674,897	\$0	\$1,088,683	\$586,214	\$0
<b>Expanded</b>					
Regular	\$40,949,622	\$20,474,811	\$0	\$0	\$20,474,811
Minor Consent	\$119,719	\$0	\$0	\$119,719	\$0
Perinatal (Title XIX)	\$53,389	\$34,703	\$0	\$18,686	\$0
Regular (Title XXI)	\$313,600	\$0	\$203,840	\$109,760	\$0
Perinatal (Title XXI)	\$2,482,885	\$0	\$1,613,875	\$869,010	\$0

**RESIDENTIAL TREATMENT SERVICES****BASE POLICY CHANGE NUMBER: 63**

<b>Mandatory</b>					
Regular	\$1,082,485	\$541,243	\$0	\$0	\$541,243
Minor Consent	\$4,434	\$0	\$0	\$4,434	\$0
Perinatal (Title XIX)	\$1,400	\$910	\$0	\$490	\$0
Regular (Title XXI)	\$8,290	\$0	\$5,388	\$2,901	\$0
Perinatal (Title XXI)	\$65,111	\$0	\$42,322	\$22,789	\$0
<b>Optional</b>					
Regular	\$7,691,805	\$7,691,805	\$0	\$0	\$0
Minor Consent	\$22,170	\$0	\$0	\$22,170	\$0
Perinatal (Title XIX)	\$9,987	\$9,987	\$0	\$0	\$0
Regular (Title XXI)	\$58,905	\$58,905	\$0	\$0	\$0
Perinatal (Title XXI)	\$464,456	\$0	\$464,456	\$0	\$0
<b>Total FY 2013-14</b>	<b>\$55,039,171</b>	<b>\$28,835,774</b>	<b>\$3,418,565</b>	<b>\$1,768,779</b>	<b>\$21,016,054</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>FF Title XIX</b>	<b>FF Title XXI</b>	<b>CF</b>	<b>GF</b>
<b>Current</b>					
Regular	\$0	\$0	\$0	\$0	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$32,201	\$20,931	\$0	\$11,270	\$0
Regular (Title XXI)	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XXI)	\$1,497,544	\$0	\$973,404	\$524,141	\$0
<b>Expanded</b>					
Regular	\$95,549,119	\$47,774,559	\$0	\$0	\$47,774,559
Minor Consent	\$283,779	\$0	\$0	\$283,779	\$0
Perinatal (Title XIX)	\$124,480	\$62,240	\$0	\$62,240	\$0
Regular (Title XXI)	\$731,734	\$0	\$475,627	\$0	\$256,107
Perinatal (Title XXI)	\$5,789,058	\$0	\$3,762,888	\$2,026,170	\$0
<b>Mandatory</b>					
Regular	\$4,602,762	\$2,301,381	\$0	\$0	\$2,301,381
Minor Consent	\$10,346	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$6,067	\$3,033	\$0	\$3,033	\$0
Regular (Title XXI)	\$35,249	\$0	\$22,912	\$0	\$12,337
Perinatal (Title XXI)	\$282,146	\$0	\$183,395	\$98,751	\$0
<b>Optional</b>					
Regular	\$20,666,960	\$20,666,960	\$0	\$0	\$0
Minor Consent	\$60,599	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$26,943	\$26,943	\$0	\$0	\$0
Regular (Title XXI)	\$158,272	\$0	\$158,272	\$0	\$0
Perinatal (Title XXI)	\$1,253,018	\$0	\$1,253,018	\$0	\$0
<b>Total FY 2014-15</b>	<b>\$131,110,277</b>	<b>\$70,856,047</b>	<b>\$6,829,515</b>	<b>\$3,009,385</b>	<b>\$50,344,385</b>

**Funding:**

50% Title XIX/50% GF (4260-101-0001/0890)

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

100% Title XIX (4260-101-0890)

## OUTPATIENT DRUG FREE TREATMENT SERVICES

**BASE POLICY CHANGE NUMBER:** 64  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1727

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$27,084,000	\$31,226,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$27,084,000	\$31,226,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$27,084,000	\$31,226,000

### 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)

**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.

Currently, the DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Effective July 1, 2011, the funds to cover the non-federal share of cost were realigned to counties as County Funds (CF). Funding for the services is generally 50% county funds and 50% Title XIX federal funds. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this mandatory and optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon those without health coverage. These mandatory requirements will likely encourage many individuals who are currently eligible but not enrolled in Medi-Cal to enroll in the program.

The mandatory expansion population refers to the population who is currently eligible for Medi-Cal but is not enrolled. This population is expected to enroll and access Medi-Cal services starting January 1, 2014. For this population's services, County Funds (CF) will be used to match federal funds. Funding for the services is 50% CF and 50% Title XIX federal funds.

The optional expansion population is currently not eligible for Medi-Cal but will become eligible for Medi-Cal starting January 1, 2014. This population is expected to enroll access Medi-Cal services starting January 1, 2014. Funding for the services is 100% Title XIX federal funds.

For the November 2013 Estimate, the DMC program changed the methodology used to compute average annual caseload. In prior years, the annual caseload was based on the sum of the four quarters of CalOMS caseload data. Presently, the program uses actual DMC billing data to determine unique client caseload. In addition, caseload is now based on 36 months of recent data instead of the 20 quarters previously used.

For FY 2014-15, the DMC reimbursement rate will be adjusted to eliminate the 10% county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. The county administration costs will be paid under a quarterly invoicing process. The county administration costs can be found in the policy change titled DMC County Admin.

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

- Beginning January 2014, ODF services will be expanded to additional newly eligible Medi-Cal beneficiaries as a result of the ACA expansion.
- The new caseload methodology reduced the caseload projections for the ODF population.

### **Methodology:**

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for DMC beginning January 2014. Additional caseload data for the expanded eligibles was developed for mandatory and optional populations expected to access this service in January 2014.
5. Assume the caseload projection for the optional expansion population is 2,808 for FY 2013-14 and 6,612 for FY 2014-15.

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

6. Assume the caseload projection for the mandatory expansion population is 396 for FY 2013-14 and 1,549 for FY 2014-15.
7. The Units of Service (UOS) data is based on the most recent complete data, July 2011-June 2012, to calculate an average UOS.
8. 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 2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 required rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

ODF	FY 2009-10 UOS Rate	CIP Deflator	FY 2013-14 Rates*	FY 2013-14 Developed Rates	FY 2013-14 Required Rates
Regular					
Individual	\$66.53	8.7%	\$72.32	\$77.10	\$72.32
Group	\$28.27	8.7%	\$30.73	\$29.39	\$29.39
Perinatal					
Individual	\$95.23	8.7%	\$103.52	\$120.38	\$103.52
Group	\$57.26	8.7%	\$62.24	\$66.65	\$62.24

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

9. The cost estimate is developed by the following: Caseload x UOS x Rate.

<b>FY 2013-14</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current Population</b>				
<b>Regular</b>				
Individual	40,352	2.7	\$72.32	\$7,879,293
Group	40,352	28.2	\$29.39	\$33,443,657
Total				\$41,322,950
<b>EPSDT</b>				
Individual	14,106	2.8	\$72.32	\$2,856,409
Group	14,106	17.6	\$29.39	\$7,296,526
Total				\$10,152,935
<b>Minor Consent</b>				
Individual	18,491	3.4	\$72.32	\$4,546,715
Group	18,491	29.9	\$29.39	\$16,249,170
Total				\$20,795,885
<b>Perinatal</b>				
Individual	769	1.6	\$103.52	\$127,371
Group	769	13.1	\$62.24	\$627,000
Total				\$754,371

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

<b>Mandatory*</b>	396			
<b>Regular</b>				
Individual	214	2.7	\$72.32	\$41,786
Group	214	28.2	\$29.39	\$177,363
Total				\$219,149
<b>EPSDT</b>				
Individual	74	2.8	\$72.32	\$14,985
Group	74	17.6	\$29.39	\$38,278
Total				\$53,262
<b>Minor Consent</b>				
Individual	105	3.4	\$72.32	\$25,818
Group	105	29.9	\$29.39	\$92,270
Total				\$118,088
<b>Perinatal</b>				
Individual	3	1.6	\$103.52	\$497
Group	3	13.1	\$62.24	\$2,446
Total				\$2,943
<b>Optional</b>				
<b>Regular</b>				
Individual	1,516	2.7	\$72.32	\$296,020
Group	1,516	28.2	\$29.39	\$1,256,458
Total				\$1,552,478
<b>EPSDT</b>				
Individual	522	2.8	\$72.32	\$105,703
Group	522	17.6	\$29.39	\$270,012
Total				\$375,715
<b>Minor Consent</b>				
Individual	748	3.4	\$72.32	\$183,924
Group	748	29.9	\$29.39	\$657,313
Total				\$841,237
<b>Perinatal</b>				
Individual	22	1.6	\$103.52	\$3,644
Group	22	13.1	\$62.24	\$17,938
Total				\$21,581
<b>FY 2014-15</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current Population</b>				
<b>Regular</b>				
Individual	41,315	2.7	\$72.32	\$8,067,332
Group	41,315	28.2	\$29.39	\$34,241,789
Total				\$42,309,122
<b>EPSDT</b>				
Individual	14,738	2.8	\$72.32	\$2,984,386
Group	14,738	17.6	\$29.39	\$7,623,437
Total				\$10,607,823

**OUTPATIENT DRUG FREE TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 64

<b>Minor Consent</b>				
Individual	18,734	3.4	\$72.32	\$4,606,466
Group	18,734	29.9	\$29.39	<u>\$16,462,709</u>
Total				\$21,069,174
<b>Perinatal</b>				
Individual	846	1.6	\$103.52	\$140,125
Group	846	13.1	\$62.24	<u>\$689,781</u>
Total				\$829,906
<b>Mandatory*</b>	1,549			
<b>Regular</b>				
Individual	836	2.7	\$72.32	\$163,241
Group	836	28.2	\$29.39	<u>\$692,875</u>
Total				\$856,116
<b>EPSDT</b>				
Individual	287	2.8	\$72.32	\$58,116
Group	287	17.6	\$29.39	<u>\$148,455</u>
Total				\$206,571
<b>Minor Consent</b>				
Individual	412	3.4	\$72.32	\$101,306
Group	412	29.9	\$29.39	<u>\$362,050</u>
Total				\$463,355
<b>Perinatal</b>				
Individual	14	1.6	\$103.52	\$2,319
Group	14	13.1	\$62.24	<u>\$11,415</u>
Total				\$13,734
<b>Optional</b>				
<b>Regular</b>				
Individual	3,571	2.7	\$72.32	\$697,288
Group	3,571	28.2	\$29.39	<u>\$2,959,638</u>
Total				\$3,656,925
<b>EPSDT</b>				
Individual	1,228	2.8	\$72.32	\$248,665
Group	1,228	17.6	\$29.39	<u>\$635,200</u>
Total				\$883,865
<b>Minor Consent</b>				
Individual	1,762	3.4	\$72.32	\$433,255
Group	1,762	29.9	\$29.39	<u>\$1,548,377</u>
Total				\$1,981,632
<b>Perinatal</b>				
Individual	51	1.6	\$103.52	\$8,447
Group	51	13.1	\$62.24	<u>\$41,583</u>
Total				\$50,030

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

10. 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.

Fiscal Year	Accrual	FY 2013-14	FY 2014-15
Regular	\$45,854,000	\$11,464,000	\$0
Minor Consent	\$17,238,000	\$4,309,000	\$0
Perinatal	\$421,000	\$105,000	\$0
<b>FY 2012-13</b>	<b>\$63,513,000</b>	<b>\$15,878,000</b>	<b>\$0</b>
<b>Current</b>			
Regular	\$51,475,884	\$38,606,913	\$12,868,971
Minor Consent	\$20,795,885	\$15,596,913	\$5,198,971
Perinatal	\$754,371	\$565,778	\$188,593
<b>Mandatory</b>			
Regular	\$272,412	\$204,309	\$68,103
Minor Consent	\$118,088	\$88,566	\$29,522
Perinatal	\$2,943	\$2,207	\$736
<b>Optional</b>			
Regular	\$1,928,193	\$1,446,145	\$482,048
Minor Consent	\$841,237	\$630,928	\$210,309
Perinatal	\$21,581	\$16,186	\$5,395
<b>FY 2013-14</b>	<b>\$76,210,594</b>	<b>\$57,157,945</b>	<b>\$19,052,648</b>
<b>Current</b>			
Regular	\$52,916,944	\$0	\$39,687,708
Minor Consent	\$21,069,174	\$0	\$15,801,881
Perinatal	\$829,906	\$0	\$622,429
<b>Mandatory</b>			
Regular	\$1,062,687	\$0	\$797,015
Minor Consent	\$463,355	\$0	\$347,517
Perinatal	\$13,734	\$0	\$10,300
<b>Optional</b>			
Regular	\$4,540,791	\$0	\$3,405,593
Minor Consent	\$1,981,632	\$0	\$1,486,224
Perinatal	\$50,030	\$0	\$37,522
<b>FY 2014-15</b>	<b>\$82,928,252</b>	<b>\$0</b>	<b>\$62,196,189</b>

11. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consent (MC) costs are funded by the counties. Newly eligible beneficiaries in the expanded and mandatory categories are funded 50% GF and 50% CF. Beneficiaries in the optional category are funded 100% FFP.

**OUTPATIENT DRUG FREE TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 64

<b>FY 2013-14</b>	<b>TF</b>	<b>FF (Title XIX)</b>	<b>FF (Title XXI)</b>	<b>County</b>	<b>GF</b>
<b>Current</b>					
Regular	\$49,690,374	\$24,845,187	\$0	\$24,845,187	\$0
Minor Consent	\$19,905,913	\$0	\$0	\$19,905,913	\$0
Perinatal (Title XIX)	\$14,120	\$9,178	\$0	\$4,942	\$0
Regular (Title XXI)	\$380,539	\$0	\$247,350	\$133,189	\$0
Perinatal (Title XXI)	\$656,658	\$0	\$426,828	\$229,830	\$0
<b>Expanded</b>					
Regular	\$0	\$0	\$0	\$0	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$0	\$0	\$0	\$0	\$0
Regular (Title XXI)	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XXI)	\$0	\$0	\$0	\$0	\$0
<b>Mandatory</b>					
Regular	\$202,756	\$101,378	\$0	\$101,378	\$0
Minor Consent	\$88,566	\$0	\$0	\$88,566	\$0
Perinatal (Title XIX)	\$46	\$30	\$0	\$16	\$0
Regular (Title XXI)	\$1,553	\$0	\$1,009	\$543	\$0
Perinatal (Title XXI)	\$2,161	\$0	\$1,404	\$756	\$0
<b>Optional</b>					
Regular	\$1,435,154	\$1,435,154	\$0	\$0	\$0
Minor Consent	\$630,928	\$0	\$0	\$630,928	\$0
Perinatal (Title XIX)	\$341	\$341	\$0	\$0	\$0
Regular (Title XXI)	\$10,991	\$0	\$10,991	\$0	\$0
Perinatal (Title XXI)	\$15,845	\$0	\$15,845	\$0	\$0
<b>Total FY 2013-14</b>	<b>\$73,035,945</b>	<b>\$26,391,268</b>	<b>\$692,437</b>	<b>\$45,941,250</b>	<b>\$0</b>
<b>FY 2014-15</b>					
	<b>TF</b>	<b>FF (Title XIX)</b>	<b>FF (Title XXI)</b>	<b>County</b>	<b>GF</b>
<b>Current</b>					
Regular	\$52,157,249	\$26,078,624	\$0	\$26,078,624	\$0
Minor Consent	\$21,000,852	\$0	\$0	\$21,000,852	\$0
Perinatal (Title XIX)	\$17,072	\$11,097	\$0	\$5,975	\$0
Regular (Title XXI)	\$399,431	\$0	\$259,630	\$139,801	\$0
Perinatal (Title XXI)	\$793,950	\$0	\$516,067	\$277,882	\$0
<b>Expanded</b>					
Regular	\$0	\$0	\$0	\$0	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XIX)	\$0	\$0	\$0	\$0	\$0
Regular (Title XXI)	\$0	\$0	\$0	\$0	\$0
Perinatal (Title XXI)	\$0	\$0	\$0	\$0	\$0
<b>Mandatory</b>					
Regular	\$858,543	\$429,272	\$0	\$429,272	\$0
Minor Consent	\$377,039	\$0	\$0	\$377,039	\$0
Perinatal (Title XIX)	\$232	\$151	\$0	\$81	\$0
Regular (Title XXI)	\$6,575	\$0	\$4,274	\$2,301	\$0
Perinatal (Title XXI)	\$10,804	\$0	\$7,022	\$3,781	\$0
<b>Optional</b>					
Regular	\$3,858,095	\$3,858,095	\$0	\$0	\$0
Minor Consent	\$1,696,533	\$0	\$0	\$1,696,533	\$0
Perinatal (Title XIX)	\$790	\$513	\$0	\$0	\$0
Regular (Title XXI)	\$29,546	\$0	\$19,205	\$0	\$0
Perinatal (Title XXI)	\$42,128	\$0	\$42,128	\$0	\$0
<b>Total FY 2014-15</b>	<b>\$81,248,838</b>	<b>\$30,377,752</b>	<b>\$848,326</b>	<b>\$50,012,142</b>	<b>\$0</b>

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

**Funding:**

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

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

## INTENSIVE OUTPATIENT SERVICES

**BASE POLICY CHANGE NUMBER:** 65  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1726

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$32,160,000	\$61,300,000
- STATE FUNDS	\$7,823,000	\$18,647,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$32,160,000	\$61,300,000
STATE FUNDS	\$7,823,000	\$18,647,000
FEDERAL FUNDS	\$24,337,000	\$42,653,000

### DESCRIPTION

**Purpose:**

This policy change estimates the reimbursement funds for the Drug Medi-Cal (DMC), Intensive Outpatient Treatment (IOT) services, previously titled Day Care Rehabilitative Services.

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(6); 51341.1 (d)(3), and 51516.1 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Day Care Rehabilitative IOT services are provided to beneficiaries with substance use disorder diagnoses. These 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.

Currently, the DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Effective July 1, 2011, the funds to cover the non-federal share of cost were realigned to counties as County Funds (CF). Funding for the services is 50% county funds and 50% Title XIX federal funds. Certain aid codes are eligible for Title XXI federal reimbursement at 65%. Until December 31, 2013 this service was limited to Early and Periodic Screening Diagnosis and Treatment

## INTENSIVE OUTPATIENT SERVICES

BASE POLICY CHANGE NUMBER: 65

(EPSDT), pregnant and postpartum women.

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this expanded, mandatory, and optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon those without health coverage. These mandatory requirements will likely encourage many individuals who are currently eligible but not enrolled in Medi-Cal to enroll in the program.

The expanded population refers to the population who are eligible and enrolled in Medi-Cal now, but are not receiving this service because it is currently not available to them. This population is expected to enroll in Medi-Cal and access this service starting January 1, 2014. Funding for the services is 50% GF and 50% Title XIX federal funds.

The mandatory expansion population refers to the population who is currently eligible for Medi-Cal but is not enrolled. This population is expected to enroll and access Medi-Cal services starting January 1, 2014. For this population's services, General Funds (GF) will be used to match federal funds. Funding for the services is 50% GF and 50% Title XIX federal funds.

The optional expansion population is currently not eligible for Medi-Cal but will become eligible for Medi-Cal starting January 1, 2014. This population is expected to enroll access Medi-Cal services starting January 1, 2014. Funding for the services is 100% Title XIX federal funds.

For the November 2013 Estimate, the DMC program changed the methodology used to compute average annual caseload. In prior years, the annual caseload was based on the sum of the four quarters of CalOMS caseload data. Presently, the program uses actual DMC billing data to determine unique client caseload. In addition, caseload is now based on 36 months of recent data instead of the 20 quarters previously used.

For FY 2014-15, the DMC reimbursement rate will be adjusted to eliminate the 10% county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. The county administration costs will be paid under a quarterly invoicing process. The county administration costs can be found in the policy change titled DMC County Admin.

### Reason for Change from Prior Estimate:

- Beginning January 2014, IOT services will be expanded to additional newly eligible Medi-Cal beneficiaries as a result of the ACA expansion.
- The new caseload methodology reduced the caseload projections for the current IOT population.

### 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 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for

**INTENSIVE OUTPATIENT SERVICES****BASE POLICY CHANGE NUMBER: 65**

DMC beginning January 2014. Additional caseload data for the expanded eligibles was developed for mandatory and optional populations expected to access this service in January 2014.

5. Assume the caseload projection for the expansion population is 11,929 for FY 2013-14 (based on six months January 2014-July 2014) and 23,858 for FY 2014-15.
6. Assume mandatory expansion population is 317 for FY 2013-14 and 1,238 for FY 2014-15.
7. Assume optional expansion population is 2,243 for FY 2013-14 and 5,282 for FY 2014-15.
8. The Units of Service (UOS) is based on the most recent complete data, July 2011-June 2012 to calculate an average UOS.
9. 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 2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

<b>IOT</b>	<b>FY 2009-10 UOS Rate</b>	<b>CIP Deflator</b>	<b>FY 2013-14 Rates *</b>	<b>FY 2013-14 Developed Rates</b>	<b>FY 2013-14 Required Rates</b>
Regular	\$61.05	8.7%	\$66.36	\$62.15	\$62.15
Perinatal	\$73.04	8.7%	\$79.39	\$85.32	\$79.39

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

10. The cost estimate is developed by the following: Caseload x UOS x Rate.

<b>FY 2013-14</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current</b>				
Regular & EPSDT	13,944	29.4	\$62.15	\$25,478,616
Perinatal	666	21.6	\$79.39	\$1,142,073
Total				\$26,620,689
<b>Expanded</b>				
Regular & EPSDT	11,208	29.4	\$62.15	\$20,479,370
Minor Consent	33	21.6	\$62.15	\$44,301
Perinatal	688	21.6	\$79.39	\$1,179,799
Total				\$21,703,469
<b>Mandatory</b>				
Regular & EPSDT	297	29.4	\$62.15	\$542,681
Minor Consent	1	21.6	\$62.15	\$1,342
Perinatal	19	21.6	\$79.39	\$32,582
Total				\$576,605

**INTENSIVE OUTPATIENT SERVICES**

BASE POLICY CHANGE NUMBER: 65

**Optional**

Regular & EPSDT	2,107	29.4	\$62.15	\$3,849,931
Minor Consent	6	21.6	\$62.15	\$8,055
Perinatal	130	21.6	\$79.39	\$222,927
Total				\$4,080,913

<b>FY 2014-15</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current</b>				
Regular & EPSDT	14,986	29.4	\$62.15	\$27,382,569
Perinatal	646	21.6	\$79.39	\$1,107,776
Total				\$28,490,345
<b>Expanded</b>				
Regular & EPSDT	22,416	29.4	\$62.15	\$40,958,739
Minor Consent	66	21.6	\$62.15	\$88,601
Perinatal	1,376	21.6	\$79.39	\$2,359,598
Total				\$43,406,938
<b>Mandatory*</b>				
Regular & EPSDT	1,164	29.4	\$62.15	\$2,126,872
Minor Consent	4	21.6	\$62.15	\$5,370
Perinatal	70	21.6	\$79.39	\$120,038
Total				\$2,252,280
<b>Optional</b>				
Regular & EPSDT	4,963	29.4	\$62.15	\$9,068,443
Minor Consent	15	21.6	\$62.15	\$20,137
Perinatal	304	21.6	\$79.39	\$521,306
Total				\$9,609,886

11. 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.

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
Regular	\$20,204,000	\$5,051,000	\$0
Perinatal	\$770,000	\$193,000	\$0
<b>FY 2012-13</b>	<b>\$20,974,000</b>	<b>\$5,244,000</b>	<b>\$0</b>
<b>Current</b>			
Regular	\$25,478,616	\$19,108,962	\$6,369,654
Perinatal	\$1,142,073	\$856,555	\$285,518
<b>Expanded</b>			
Regular	\$20,479,370	\$15,359,527	\$5,119,842
Minor Consent	\$44,301	\$33,225	\$11,075
Perinatal	\$1,179,799	\$884,849	\$294,950
<b>Mandatory</b>			
Regular	\$542,681	\$407,011	\$135,670

**INTENSIVE OUTPATIENT SERVICES**

BASE POLICY CHANGE NUMBER: 65

Minor Consent	\$1,342	\$1,007	\$336
Perinatal	\$32,582	\$24,436	\$8,145
<b>Optional</b>			
Regular	\$3,849,931	\$2,887,449	\$962,483
Minor Consent	\$8,055	\$6,041	\$2,014
Perinatal	\$222,927	\$167,195	\$55,732
<b>FY 2013-14</b>	<b>\$52,982,000</b>	<b>\$39,736,500</b>	<b>\$13,245,500</b>
<b>Current</b>			
Regular	\$27,382,569	\$0	\$20,536,927
Perinatal	\$1,107,776	\$0	\$830,832
<b>Expanded</b>			
Regular	\$40,958,739	\$0	\$30,719,055
Minor Consent	\$88,601	\$0	\$66,451
Perinatal	\$2,359,598	\$0	\$1,769,698
<b>Mandatory</b>			
Regular	\$2,126,872	\$0	\$1,595,154
Minor Consent	\$5,370	\$0	\$4,027
Perinatal	\$120,038	\$0	\$90,028
<b>Optional</b>			
Regular	\$9,068,443	\$0	\$6,801,332
Minor Consent	\$20,137	\$0	\$15,102
Perinatal	\$521,306	\$0	\$390,980
<b>FY 2014-15</b>	<b>\$83,759,450</b>	<b>\$0</b>	<b>\$62,819,587</b>

12. Funding is 50% CF and 50% Federal Funds Participation (FFP). Minor consent costs are funded by the counties. Newly eligible beneficiaries in the expanded and mandatory categories are funded 50% GF and 50% FFP. Beneficiaries in the optional category are funded 100% FFP.

<u>FY 2013-14</u>	<u>TF</u>	<u>FFP Title XIX</u>	<u>FFP Title XXI</u>	<u>CF</u>	<u>GF</u>
<b>Current</b>					
Regular	\$23,976,346	\$11,988,173	\$0	\$11,988,173	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Regular (Title XXI)	\$22,093	\$14,361	\$0	\$7,733	\$0
Perinatal (Title XXI)	\$183,616	\$0	\$119,350	\$64,265	\$0
Perinatal (Title XXI)	\$1,027,461	\$0	\$667,850	\$359,612	\$0
<b>Expanded</b>					
Regular	\$15,242,795	\$7,621,397	\$0	\$0	\$7,621,397
Minor Consent	\$33,225	\$0	\$0	\$33,225	\$0
Regular (Title XXI)	\$18,626	\$12,107	\$0	\$6,519	\$0
Perinatal (Title XXI)	\$116,732	\$0	\$75,876	\$40,856	\$0
Perinatal (Title XXI)	\$866,223	\$0	\$563,045	\$303,178	\$0
<b>Mandatory</b>					
Regular	\$403,918	\$201,959	\$0	\$0	\$201,959

**INTENSIVE OUTPATIENT SERVICES****BASE POLICY CHANGE NUMBER: 65**

Minor Consent	\$1,007	\$0	\$0	\$1,007	\$0
Regular (Title XXI)	\$514	\$334	\$0	\$180	\$0
Perinatal (Title XXI)	\$3,093	\$0	\$2,011	\$1,083	\$0
Perinatal (Title XXI)	\$23,922	\$0	\$15,549	\$8,373	\$0
<b>Optional</b>					
Regular	\$2,865,504	\$2,865,504	\$0	\$0	\$0
Minor Consent	\$6,041	\$0	\$0	\$6,041	\$0
Regular (Title XXI)	\$3,519	\$3,519	\$0	\$0	\$0
Perinatal (Title XXI)	\$21,945	\$0	\$21,945	\$0	\$0
Perinatal (Title XXI)	\$163,676	\$0	\$163,676	\$0	\$0
<b>Total FY 2013-14</b>	<b>\$44,980,258</b>	<b>\$22,707,355</b>	<b>\$1,629,302</b>	<b>\$12,820,245</b>	<b>\$7,823,356</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>FF Title XIX</b>	<b>FF Title XXI</b>	<b>CF</b>	<b>GF</b>
<b>Current</b>					
Regular	\$26,702,091	\$13,351,045	\$0	\$13,351,045	\$0
Minor Consent	\$0	\$0	\$0	\$0	\$0
Regular (Title XXI)	\$8,484	\$5,515	\$0	\$2,969	\$0
Perinatal (Title XXI)	\$204,490	\$0	\$132,919	\$71,572	\$0
Perinatal (Title XXI)	\$1,107,866	\$0	\$720,113	\$387,753	\$0
<b>Expanded</b>					
Regular	\$35,566,521	\$17,783,261	\$0	\$0	\$17,783,261
Minor Consent	\$77,526	\$0	\$0	\$77,526	\$0
Regular (Title XXI)	\$43,461	\$28,250	\$0	\$15,211	\$0
Perinatal (Title XXI)	\$272,376	\$0	\$177,044	\$95,331	\$0
Perinatal (Title XXI)	\$2,021,187	\$0	\$1,313,772	\$707,416	\$0
<b>Mandatory</b>					
Regular	\$1,717,670	\$858,835	\$0	\$0	\$858,835
Minor Consent	\$4,363	\$0	\$0	\$4,363	\$0
Regular (Title XXI)	\$2,067	\$1,343	\$0	\$723	\$0
Perinatal (Title XXI)	\$13,154	\$0	\$8,550	\$0	\$4,604
Perinatal (Title XXI)	\$96,107	\$0	\$62,470	\$33,637	\$0
<b>Optional</b>					
Regular	\$7,704,810	\$7,704,810	\$0	\$0	\$0
Minor Consent	\$17,116	\$0	\$0	\$17,116	\$0
Regular (Title XXI)	\$8,230	\$8,230	\$0	\$0	\$0
Perinatal (Title XXI)	\$59,005	\$0	\$59,005	\$0	\$0
Perinatal (Title XXI)	\$438,482	\$0	\$438,482	\$0	\$0
<b>Total FY 2014-15</b>	<b>\$76,065,007</b>	<b>\$39,741,289</b>	<b>\$2,912,354</b>	<b>\$14,764,664</b>	<b>\$18,646,700</b>

**Funding:**

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

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

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

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

## SMHS FOR CHILDREN

**BASE POLICY CHANGE NUMBER:** 69  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1779

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$728,307,000	\$758,674,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$728,307,000	\$758,674,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$728,307,000	\$758,674,000

### 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 SMHS for children. A separate policy change budgets the costs associated with SMHS for adults.

## SMHS FOR CHILDREN

### BASE POLICY CHANGE NUMBER: 69

The following Medi-Cal SMHS are available 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

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

Changes are due to additional approved claims data and the elimination of the State Maximum Rate (SMA).

#### **Methodology:**

1. The costs are developed using 69 months of Short-Doyle/Medi-Cal (SD/MC) and 67 months Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2013, with dates of service from July 2007 through March 2013. The FFS data is current as of August 23, 2013, with dates of service from July 2007 through January 2013.
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.
4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

	<b>TF</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2011-12	\$1,356,716	\$1,297,860	\$58,856
FY 2012-13	\$1,405,488	\$1,337,907	\$67,581
FY 2013-14	\$1,465,995	\$1,393,448	\$72,547
FY 2014-15	\$1,526,500	\$1,448,988	\$77,512

## SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 69

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:

(Dollars In Thousands)

	TF	FFP	CF
FY 2011-12	\$1,356,716	\$682,214	\$674,502
FY 2012-13	\$1,405,488	\$706,741	\$698,747
FY 2013-14	\$1,465,995	\$737,167	\$728,828
FY 2014-15	\$1,526,500	\$767,594	\$758,906

6. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 28% of FY 2012-13 claims, and 71% of FY 2013-14 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2011-12 claims, 20% of FY 2012-13 claims, and 79% of FY 2013-14 claims. The overall cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2011-12	\$13,568	\$12,979	\$589
FY 2012-13	\$388,027	\$374,848	\$13,179
FY 2013-14	\$1,046,778	\$989,104	\$57,674
<b>Total FY 2013-14</b>	<b>\$1,448,373</b>	<b>\$1,376,931</b>	<b>\$71,442</b>

7. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 28% of FY 2013-14 claims, and 71% of FY 2014-15 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2012-13 claims, 20% of FY 2013-14 claims, and 79% of FY 2014-15 claims. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2012-13	\$14,055	\$13,379	\$676
FY 2013-14	\$404,557	\$390,409	\$14,148
FY 2014-15	\$1,090,150	\$1,028,529	\$61,621
<b>Total FY 2014-15</b>	<b>\$1,508,762</b>	<b>\$1,432,317</b>	<b>\$76,445</b>

8. 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.

(Dollars In Thousands)

Cash Estimate	TF	FFP	M-CHIP*	County
<b>Total FY 2013-14</b>	<b>\$1,448,373</b>	<b>\$710,453</b>	<b>\$17,854</b>	<b>\$720,066</b>
<b>Total FY 2014-15</b>	<b>\$1,508,762</b>	<b>\$740,072</b>	<b>\$18,602</b>	<b>\$750,088</b>

### Funding:

100% Title XIX FFP (4260-101-0890)  
100% Title XXI FFP (4260-113-0890)\*

## SMHS FOR ADULTS

**BASE POLICY CHANGE NUMBER:** 70  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1780

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$502,241,000	\$512,977,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$502,241,000	\$512,977,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$502,241,000	\$512,977,000

### 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).

This policy change budgets the costs associated with SMHS for adults. A separate policy change budgets the costs associated with SMHS for children.

## SMHS FOR ADULTS

### BASE POLICY CHANGE NUMBER: 70

The following Medi-Cal SMHS are available 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

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

Changes are due to additional approved claims data and the elimination of the State Maximum Rate (SMA).

#### **Methodology:**

1. The costs are developed using 69 months of Short-Doyle/Medi-Cal (SD/MC) and 67 months of Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2013, with dates of service from July 2007 through March 2013. The FFS data is current as of August 23, 2013, with dates of service from July 2007 through January 2013.
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:

(Dollars In Thousands)

	<u>Total</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
FY 2011-12	\$920,844	\$791,532	\$129,312
FY 2012-13	\$989,700	\$849,545	\$140,155
FY 2013-14	\$1,010,693	\$863,830	\$146,863
FY 2014-15	\$1,031,685	\$878,115	\$153,570

## SMHS FOR ADULTS

### BASE POLICY CHANGE NUMBER: 70

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:

(Dollars In Thousands)

	<b>Total</b>	<b>FFP</b>	<b>CF</b>
FY 2011-12	\$920,844	\$460,422	\$460,422
FY 2012-13	\$989,700	\$494,850	\$494,850
FY 2013-14	\$1,010,693	\$505,347	\$505,346
FY 2014-15	\$1,031,685	\$515,843	\$515,842

6. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 28% of FY 2012-13 claims, and 71% of FY 2013-14 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2011-12 claims, 20% of FY 2012-13 claims, and 79% of FY 2013-14 claims. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	<b>Total</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2011-12	\$9,208	\$7,915	\$1,293
FY 2012-13	\$265,353	\$238,021	\$27,332
FY 2013-14	\$729,922	\$613,168	\$116,754
<b>Total FY 2013-14</b>	<b>\$1,004,483</b>	<b>\$859,104</b>	<b>\$145,379</b>

7. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 28% of FY 2013-14 claims, and 71% of FY 2014-15 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2012-13 claims, 20% of FY 2013-14 claims, and 79% of FY 2014-15 claims. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	<b>Total</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2012-13	\$9,897	\$8,495	\$1,402
FY 2013-14	\$270,663	\$242,023	\$28,640
FY 2014-15	\$745,394	\$623,308	\$122,086
<b>Total FY 2014-15</b>	<b>\$1,025,954</b>	<b>\$873,826</b>	<b>\$152,128</b>

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

(Dollars In Thousands)

Cash Estimate	<b>TF</b>	<b>FFP</b>	<b>County</b>
<b>Total FY 2013-14</b>	<b>\$1,004,483</b>	<b>\$502,241</b>	<b>\$502,242</b>
<b>Total FY 2014-15</b>	<b>\$1,025,954</b>	<b>\$512,977</b>	<b>\$512,977</b>

**Funding:**

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

## TWO PLAN MODEL

**BASE POLICY CHANGE NUMBER:** 114  
**IMPLEMENTATION DATE:** 7/2000  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 56

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$7,520,181,000	\$7,847,249,000
- STATE FUNDS	\$3,743,332,500	\$3,906,757,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,520,181,000	\$7,847,249,000
STATE FUNDS	\$3,743,332,500	\$3,906,757,500
FEDERAL FUNDS	\$3,776,848,500	\$3,940,491,500

### 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 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 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. On January 1, 2013, Health Plan of San Joaquin replaced Anthem in Stanislaus County, and Health Net replaced Anthem in San Joaquin County.

#### Reason for Change from Prior Estimate:

Rates and eligibles were updated, and baseline rates were used. In the May estimate, the rates included certain policy change costs reflected in other PCs and had to be adjusted to avoid double counting of those costs. In November, the rates excluded items that were included in other policy changes and therefore no adjustment was required.

#### 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.

**TWO PLAN MODEL****BASE POLICY CHANGE NUMBER: 114**

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 2013-14 and FY 2014-15 rates include:
  - Annual rate redeterminations for FY 2013-14 and FY 2014-15.
  - LTC rate adjustments
  - Hospice rate increase
  - Elimination of inpatient hospital provider payment reduction
  - Inclusion of GHPP services
  - CBAS/Enhancement case management
  - Medicare improvements for Patients and Providers Act
  - Diagnosis related groups
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. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
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.

(Dollars in Thousands)

<b>FY 2013-14</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	1,991,698	\$457,452
Contra Costa	1,127,613	\$245,756
Kern	1,977,289	\$326,717
Los Angeles	18,205,266	\$3,232,681
Riverside	3,417,235	\$573,109
San Bernardino	4,082,100	\$677,272
San Francisco	875,903	\$256,434
San Joaquin	1,598,595	\$286,909
Santa Clara	1,923,406	\$365,433
Stanislaus	1,003,908	\$199,570
Tulare	1,496,108	\$244,758
Fresno	2,837,790	\$537,978
Kings	308,164	\$54,787
Madera	375,541	\$61,325
<b>Total FY 2013-14</b>	<b>41,220,616</b>	<b>\$7,520,181</b>

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 114**

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	2,039,646	\$479,455
Contra Costa	1,150,021	\$254,334
Kern	2,006,293	\$337,928
Los Angeles	18,400,222	\$3,387,793
Riverside	3,486,746	\$598,752
San Bernardino	4,199,428	\$705,842
San Francisco	890,238	\$267,054
San Joaquin	1,638,676	\$298,060
Santa Clara	1,958,932	\$379,996
Stanislaus	1,009,662	\$202,568
Tulare	1,519,190	\$253,145
Fresno	2,897,576	\$559,511
Kings	313,521	\$57,884
Madera	382,895	\$64,927
<b>Total FY 2014-15</b>	<b>41,893,046</b>	<b>\$7,847,249</b>

**Funding:**  
(in Thousands)

**FY 2013-14:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$3,717,215	\$3,717,215	\$7,434,429
State GF	4260-101-0001	\$19,492		\$19,492
Family Planning 90/10 GF	4260-101-0001/0890	\$6,626	\$59,634	\$66,260
<b>Total</b>		<b>\$3,743,333</b>	<b>\$3,776,849</b>	<b>\$7,520,181</b>

**FY 2014-15:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$3,880,858	\$3,880,858	\$7,761,715
State GF	4260-101-0001	\$19,274		\$19,274
Family Planning 90/10 GF	4260-101-0001/0890	\$6,626	\$59,634	\$66,260
<b>Total</b>		<b>\$3,906,758</b>	<b>\$3,940,492</b>	<b>\$7,847,249</b>

## COUNTY ORGANIZED HEALTH SYSTEMS

**BASE POLICY CHANGE NUMBER:** 115  
**IMPLEMENTATION DATE:** 12/1987  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 57

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$3,567,054,000	\$3,607,617,000
- STATE FUNDS	\$1,777,061,500	\$1,797,114,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,567,054,000	\$3,607,617,000
STATE FUNDS	\$1,777,061,500	\$1,797,114,100
FEDERAL FUNDS	\$1,789,992,500	\$1,810,502,900

### 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 142 Discontinue Undocumented Beneficiaries from PHC  
 PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 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 expanded into eight counties effective September 1, 2013. These counties include Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Additional information can be found in the Managed Care Expansion to Rural Counties Policy Change.

**Reason for Change from Prior Estimate:**

Rates and eligibles were updated, and baseline rates were used. In the May estimate, the rates included certain policy change costs reflected in other PCs and had to be adjusted to avoid double counting of those costs. In November, the rates excluded items that were included in other policy changes and therefore no adjustment was required.

## COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 115

### 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 2013-14 and FY 2014-15 rates include:
  - Annual rate redeterminations for FY 2013-14 and FY 2014-15.
  - LTC rate adjustments
  - Hospice rate increase
  - Elimination of inpatient hospital provider payment reduction
  - CBAS/Enhancement case management
  - Medicare improvements for Patients and Providers Act
  - Elimination of retroactive payments
  - Diagnosis related groups
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) extended the Gross Premium Tax through June 30, 2012. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
6. The FY 2013-14 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.
7. 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.

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 115

8. The Department receives federal reimbursement of 90% for family planning services.

(Dollars in Thousands) <b>FY 2013-14</b>	<b>Eligible Months</b>	<b>Total</b>
San Luis Obispo	333,841	\$94,488
Santa Barbara	765,617	\$217,317
San Mateo	713,211	\$325,061
Solano	728,952	\$240,916
Santa Cruz	417,698	\$130,251
CalOPTIMA(Orange)	4,667,722	\$1,247,623
Napa	168,968	\$58,904
Monterey	908,186	\$238,591
Yolo	324,792	\$109,693
Sonoma	657,181	\$222,858
Merced	890,915	\$190,639
Marin	206,529	\$104,226
Mendocino	243,541	\$74,213
Ventura	1,194,067	\$312,274
<b>Total FY 2013-14 (Rounded)</b>	<b>12,221,220</b>	<b>\$3,567,054</b>

(Dollars in Thousands) <b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
San Luis Obispo	337,347	\$95,067
Santa Barbara	773,655	\$219,051
San Mateo	724,989	\$329,480
Solano	737,675	\$244,537
Santa Cruz	421,093	\$131,685
CalOPTIMA (Orange)	4,746,112	\$1,267,023
Napa	173,195	\$60,242
Monterey	917,623	\$241,085
Yolo	329,712	\$111,032
Sonoma	668,841	\$225,435
Merced	897,611	\$192,028
Marin	206,448	\$104,236
Mendocino	243,608	\$74,264
Ventura	1,195,109	\$312,452
<b>Total FY 2014-15 (Rounded)</b>	<b>12,373,018</b>	<b>\$3,607,617</b>

## COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 115

### Funding: (In Thousands)

#### FY 2013-14:

		<u>GF</u>	<u>FF</u>	<u>TF</u>
Title XIX 50/50 FFP	4260-101-0001/0890	\$1,772,753	\$1,772,753	\$3,545,506
State GF	4260-101-0001	\$2,393		\$2,393
Family Planning 90/10 GF	4260-101-0001/0890	\$1,915	\$17,240	\$19,155
<b>Total</b>		<b>\$1,777,061</b>	<b>\$1,789,993</b>	<b>\$3,567,054</b>

#### FY 2014-15:

		<u>GF</u>	<u>FF</u>	<u>TF</u>
Title XIX 50/50 FFP	4260-101-0001/0890	\$1,792,637	\$1,792,637	\$3,585,274
State GF	4260-101-0001	\$2,492		\$2,492
Family Planning 90/10 GF	4260-101-0001/0890	\$1,985	\$17,866	\$19,851
<b>Total</b>		<b>\$1,797,114</b>	<b>\$1,810,503</b>	<b>\$3,607,617</b>

## GEOGRAPHIC MANAGED CARE

**BASE POLICY CHANGE NUMBER:** 116  
**IMPLEMENTATION DATE:** 4/1994  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 58

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$1,273,660,000	\$1,357,157,000
- STATE FUNDS	\$634,729,500	\$676,411,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,273,660,000	\$1,357,157,000
STATE FUNDS	\$634,729,500	\$676,411,000
FEDERAL FUNDS	\$638,930,500	\$680,746,000

### 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 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 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:**

Rates and eligibles were updated, and baseline rates were used. In the May estimate, the rates included certain policy change costs reflected in other PCs and had to be adjusted to avoid double counting of those costs. In November, the rates excluded items that were included in other policy changes and therefore no adjustment was required.

**Methodology:**

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.
2. The GMC program requires mandatory enrollment for most of Public Assistance, Medically Needy, Medically Indigent Children, Refugee beneficiaries, and Poverty aid codes.

**GEOGRAPHIC MANAGED CARE****BASE POLICY CHANGE NUMBER: 116**

3. The FY 2013-14 and FY 2014-15 rates include:
  - Annual rate redeterminations for FY 2013-14 and FY 2014-15.
  - LTC rate adjustments
  - Hospice rate increase
  - Elimination of inpatient hospital provider payment reduction
  - CBAS/Enhancement Case Management
  - Medicare improvements for Patients and Providers Act
  - Diagnosis related groups
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. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
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 2013-14 and FY 2014-15 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

(Dollars in Thousands)

<b>FY 2013-14</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento GMC	2,867,811	\$564,353
San Diego GMC	3,447,642	\$709,307
<b>Total FY 2013-14</b>	<b>6,315,453</b>	<b>\$1,273,660</b>

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento GMC	2,906,242	\$601,922
San Diego GMC	3,503,998	\$755,235
<b>Total FY 2014-15</b>	<b>6,410,240</b>	<b>\$1,357,157</b>

**Funding:**

(Rounded in Thousands)

**FY 2013-14:**

		<b>GF</b>	<b>FF</b>	<b>TF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$630,934	\$630,934	\$1,261,868
State GF	4260-101-0001	\$ 2,907	\$ 0	\$ 2,907
Family Planning 90/10 FFP	4260-101-0001/0890	\$ 888	\$ 7,997	\$ 8,885
<b>Total</b>		<b>\$634,729</b>	<b>\$638,931</b>	<b>\$1,273,660</b>

**GEOGRAPHIC MANAGED CARE**

BASE POLICY CHANGE NUMBER: 116

**FY 2014-15:**

		<u>GF</u>	<u>FF</u>	<u>TF</u>
Title XIX 50/50 FFP	4260-101-0001/0890	\$ 672,749	\$672,750	\$1,345,499
State GF	4260-101-0001	\$ 2,773	\$ 0	\$ 2,773
Family Planning 90/10 FFP	4260-101-0001/0890	\$ 889	\$ 7,996	\$ 8,885
<b>Total</b>		<b>\$ 676,411</b>	<b>\$680,746</b>	<b>\$1,357,157</b>

## PACE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 122  
**IMPLEMENTATION DATE:** 7/1992  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 62

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$196,190,000	\$262,614,000
- STATE FUNDS	\$98,095,000	\$131,307,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$196,190,000	\$262,614,000
STATE FUNDS	\$98,095,000	\$131,307,000
FEDERAL FUNDS	\$98,095,000	\$131,307,000

### 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:**

Not Applicable

**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 begin operations 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 (UPL). PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

**Reason for Change from Prior Estimate:**

Implementation dates for the new PACE organizations have been delayed due to delays within each PACE organization.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 122**

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
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	December 1, 2013
Central Valley Medical Svcs.	Fresno	January 1, 2014
Redwood Coast	Humboldt	May 1, 2014

**Methodology:**

1. Assume the 2013 and 2014 rates are calculated using the UPL for each year. The 2015 rates will be calculated using the existing comparable population UPL methodology.
2. FY 2013-14 and FY 2014-15 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.
4. The Department is working with PACE organizations and proposing changes to current law to transition from a UPL-based methodology to an actuarially sound experienced-based methodology. The Department anticipates restructuring the methodology to determine the rates beginning in January 2015.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 122**

<b>FY 2013-14</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Center for Elders'			
Independence	\$33,199,000	8,003	667
Sutter Senior Care	\$11,267,000	2,961	247
AltaMed Senior BuenaCare	\$66,117,000	18,710	1,559
On Lok Lifeways	\$63,992,000	15,235	1,270
St. Paul's PACE	\$15,367,000	4,195	350
Los Angeles Jewish Homes	\$2,805,000	865	72
CalOptima	\$1,215,000	390	33
InnovAge	\$2,098,000	630	53
Central Valley Medical Svs.	\$130,000	34	3
Redwood Coast	\$527,000	150	13
<b>Total Capitation Payments</b>	<b>\$196,190,000</b>	<b>51,173</b>	<b>4,267</b>
<b>FY 2014-15</b>			
Center for Elders'			
Independence	\$47,071,000	11,499	958
Sutter Senior Care	\$13,340,000	3,523	294
Alta Med Senior BuenaCare	\$77,735,000	21,965	1,830
On Lok Lifeways	\$74,287,000	17,610	1,468
St. Paul's PACE	\$21,627,000	5,826	486
Los Angeles Jewish Homes	\$6,516,000	2,028	169
CalOptima	\$3,925,000	1,260	105
InnovAge	\$13,081,000	3,930	328
Central Valley Medical Svs.	\$1,707,000	450	38
Redwood Coast	\$3,325,000	948	79
<b>Total Capitation Payments</b>	<b>\$262,614,000</b>	<b>69,039</b>	<b>5,755</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)

## DENTAL MANAGED CARE (Other M/C)

**BASE POLICY CHANGE NUMBER:** 125  
**IMPLEMENTATION DATE:** 7/2004  
**ANALYST:** Erickson Chow  
**FISCAL REFERENCE NUMBER:** 1029

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$49,050,000</b>	<b>\$49,710,000</b>
<b>- STATE FUNDS</b>	<b>\$24,525,000</b>	<b>\$24,855,000</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>\$49,050,000</b>	<b>\$49,710,000</b>
<b>STATE FUNDS</b>	<b>\$24,525,000</b>	<b>\$24,855,000</b>
<b>FEDERAL FUNDS</b>	<b>\$24,525,000</b>	<b>\$24,855,000</b>

### DESCRIPTION

**Purpose:**

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

**Authority:**

Social Security Act, Title XIX

**Interdependent Policy Changes:**

Not Applicable

**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 three 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.

**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 December 2012 are shown in the Dental Retroactive Rate Changes policy change.

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

BASE POLICY CHANGE NUMBER: 125

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.

(In Thousands)			<b>Average</b>	
		<b>Capitation</b>	<b>Monthly</b>	<b>Total Funds</b>
		<b>Rate</b>	<b>Eligibles</b>	
<b><u>FY 2013-14</u></b>				
GMC				
	<21	\$11.46	142,269	\$19,565
	21+	\$1.45	77,767	\$1,353
PHP				
	<21	\$11.46	193,290	\$26,581
	21+	\$1.45	89,123	\$1,551
<b>Total</b>				<b>\$49,050</b>
<b><u>FY 2014-15</u></b>				
GMC				
	<21	\$11.46	149,152	\$20,511
	21+	\$1.45	81,530	\$1,419
PHP				
	<21	\$11.46	190,876	\$26,249
	21+	\$1.45	88,010	\$1,531
<b>Total</b>				<b>\$49,710</b>

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 126  
**IMPLEMENTATION DATE:** 2/1985  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 61

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$40,158,000	\$39,407,000
- STATE FUNDS	\$20,079,000	\$19,703,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,158,000	\$39,407,000
STATE FUNDS	\$20,079,000	\$19,703,500
FEDERAL FUNDS	\$20,079,000	\$19,703,500

### 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 141 SCAN Transition to Managed Care  
 PC 137 Extend Gross Premium Tax  
 PC 159 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 121 Extend Gross Premium Tax – Funding Adjustment  
 PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 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. 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, 2014 through December 31, 2014 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: 126

### Reason for Change from Prior Estimate:

The estimated costs have changed resulting from final CMS approval of the 2010-11 and 2012-13 SCAN rates, which delayed the recoupment and repayment of capitation payments.

### 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 8,072 in June 2014 and 8,167 by December 2014 based on Medi-Cal eligibles data submitted by SCAN.
3. The 2012 and 2013 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for 2014 have not been finalized. Therefore, FY 2013-14 and FY 2014-15 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) 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. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
5. The Department received final CMS approval of SCAN 2010-11 rates in August 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. Both the repayment and recoupment will occur in FY 2013-14.
6. The Department received final CMS approval of SCAN 2012-13 rates in August 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 September 2013; the repayment will occur in FY 2013-14.
7. Assume SCAN participants will transition out of SCAN into Coordinated Care Initiative managed care plans beginning January 1, 2015. This transition is shown in the SCAN Transition to Managed Care policy change.

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

BASE POLICY CHANGE NUMBER: 126

<b>FY 2013-14</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Los Angeles	\$25,401,000	61,756	5,146
Riverside	\$7,469,000	19,709	1,642
San Bernardino	\$5,188,000	12,675	1,056
<b>Total</b>	<b>\$38,058,000</b>	<b>94,140</b>	<b>7,844</b>
2010-11 LTC Rate Recoupment	(\$17,300,000)		
2010-11 Aged/Disabled Rate Repayment	\$8,700,000		
2012-13 Rate Adjustment	\$10,700,000		
<b>Total FY 2013-14</b>	<b>\$40,158,000</b>		
<b>FY 2014-15</b>			
Los Angeles	\$26,297,000	63,934	5,328
Riverside	\$7,735,000	20,411	1,701
San Bernardino	\$5,375,000	13,132	1,094
<b>Total</b>	<b>\$39,407,000</b>	<b>97,477</b>	<b>8,123</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)

## AIDS HEALTHCARE CENTERS (Other M/C)

**BASE POLICY CHANGE NUMBER:** 129  
**IMPLEMENTATION DATE:** 5/1985  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 63

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$4,320,000	\$9,263,000
- STATE FUNDS	\$2,160,000	\$4,631,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,320,000	\$9,263,000
STATE FUNDS	\$2,160,000	\$4,631,500
FEDERAL FUNDS	\$2,160,000	\$4,631,500

### 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 137 Extend Gross Premium Tax  
 PC 159 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 121 Extend Gross Premium Tax – Funding Adjustment  
 PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 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 AIDS Healthcare Centers as a PCCM plan and participates 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. The shared savings for CY 2010, CY 2011, CY 2012 and beyond have not yet been determined. The Department entered into a new five year contract with AIDS Healthcare Foundation effective January 1, 2012, through December 31, 2016.

The PCCM received capitation payments at the 2011 capitation rates throughout 2012 as well as 2013. This has resulted in an overpayment to the PCCM given a reduction in capitation rates in 2012 and 2013 relative to 2011. The Department has a contractual option to recoup 25% of the overpayment on a monthly basis, retroactive to January 2012. The full recoupment is expected to be collected in

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

BASE POLICY CHANGE NUMBER: 129

January 2014.

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. SB 78 extended the 2.35% gross premium tax through June 30, 2013, and imposed a 3.9375% statewide sales tax on managed care health plans effective July 1, 2013, through July 1, 2016.

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 MCO Tax Managed Care Plans – Funding Adjustment policy change.

**Reason for Change from Prior Estimate:**

Updated legislation, eligibles, and rates, and the recoupment of retroactive rate adjustments.

**Methodology:**

1. Assume dual eligible months will be 4,200 in FY 2013-14 and FY 2014-15.
2. Assume Medi-Cal only eligible months will be 5,400 in FY 2013-14 and FY 2014-15.
3. Dual capitation rates are assumed to be \$271.22 for FY 2013-14 and \$279.55 for FY 2014-15.
4. Medi-Cal only capitation rates are assumed to be \$1,414.16 for FY 2013-14 and \$1,497.99 for FY 2014-15.

**Duals:**

FY 13/14:  $4,200 \times \$271.22 = \$1,139,000$

FY 14/15:  $4,200 \times \$279.55 = \$1,174,000$

**Medi-Cal Only:**

FY 13/14:  $5,400 \times \$1,414.16 = \$7,636,000$

FY 14/15:  $5,400 \times \$1,497.99 = \$8,089,000$

5. The total recoupment for calendar years 2012 and 2013 is estimated to be \$4,455,000.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Dual	\$1,139,000	\$1,174,000
Medi-Cal Only	\$7,636,000	\$8,089,000
Recoupment	-\$4,455,000	\$0
<b>Total (Rounded)</b>	<b>\$4,320,000</b>	<b>\$9,263,000</b>

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 130  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 66

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$2,597,000	\$2,708,000
- STATE FUNDS	\$1,298,500	\$1,354,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,597,000	\$2,708,000
STATE FUNDS	\$1,298,500	\$1,354,000
FEDERAL FUNDS	\$1,298,500	\$1,354,000

### 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 117 MCO Tax Mgd. Care Plans – Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans – Funding Adjustment  
 PC 140 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 from July 1, 2013, through June 30, 2014, and is anticipated to be extended through June 30, 2015. Additionally, the estimated number of member months for FY 2013-14 dropped from 1,577 to 1,405.

**Methodology:**

1. Assume the member months will be 1,405 for FY 2013-14 and 1,465 for FY 2013-14.
2. The Family Mosaic capitation rates are assumed to be \$1,848.75 for both FY 2013-14 and FY 2014-15.

**FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)****BASE POLICY CHANGE NUMBER: 130**

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

FY 2013-14: 1,405 x \$1,848.75 = **\$2,597,000 TF (\$1,298,500 GF)**

FY 2014-15: 1,465 x \$1,848.75 = **\$2,708,000 TF (\$1,354,000 GF)**

**Funding:**

50% Title XIX/50% GF (4260-101-0001/0890)

## PERSONAL CARE SERVICES (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 171  
**IMPLEMENTATION DATE:** 4/1993  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 22

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$2,695,250,000</b>	<b>\$2,799,250,000</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>\$2,695,250,000</b>	<b>\$2,799,250,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$2,695,250,000</b>	<b>\$2,799,250,000</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 April 1, 2014. IHSS cost related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.

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: 171

**Reason for Change from Prior Estimate:**

Updated expenditure data received from CDSS.

**Methodology:**

The following estimates, on a cash basis, were provided by CDSS.

(Dollars in Thousands)

	<u>TF</u>	<u>FFP</u>	<u>CDSS GF/ County Share</u>
<b>FY 2012-13</b>	\$5,390,500	<b>\$2,695,250</b>	\$2,695,250
<b>FY 2013-14</b>	\$5,598,500	<b>\$2,799,250</b>	\$2,799,250

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 172  
**IMPLEMENTATION DATE:** 7/1988  
**ANALYST:** Humei Wang  
**FISCAL REFERENCE NUMBER:** 76

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$2,562,827,000	\$2,701,309,000
- STATE FUNDS	\$1,363,494,500	\$1,438,340,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,562,827,000	\$2,701,309,000
STATE FUNDS	\$1,363,494,500	\$1,438,340,500
FEDERAL FUNDS	\$1,199,332,500	\$1,262,968,500

### 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:**

There is no material change.

**Methodology:**

1. This policy change also includes adjustments due to reconciliations of state and federal data.
2. The Centers for Medicare and Medicaid set the 2013 Medicare Part A premium at \$441.00 and the Medicare Part B premium at \$104.90.
3. 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%, the 2014 Medicare Part B premium is estimated to increase by \$5.30 to \$110.20.
4. Using the average 2008-2013 premium growth rate 0.88%, the 2015 Medicare Part A premium is estimated to increase by \$3.90 to \$448.80. Based on the 2013 growth rate of 5.01%, the 2015 Medicare Part B premium is estimated to increase by \$5.60 to \$115.80.

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

BASE POLICY CHANGE NUMBER: 172

<b>FY 2013-14</b>	<b>Part A</b>	<b>Part B</b>
Average Monthly Eligibles	174,100	1,206,200
Rate 07/2013-12/2013	\$441.00	\$104.90
Rate 01/2014-06/2014	\$444.90	\$110.20
<b>FY 2014-15</b>		
Average Monthly Eligibles	177,900	1,233,000
Rate 07/2014-12/2014	\$444.90	\$110.20
Rate 01/2015-06/2015	\$448.80	\$115.80

**Funding:**

State General Fund (4260-101-0001)

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

## MEDICARE PAYMENTS - PART D PHASED-DOWN

**BASE POLICY CHANGE NUMBER:** 173  
**IMPLEMENTATION DATE:** 1/2006  
**ANALYST:** Jade Li  
**FISCAL REFERENCE NUMBER:** 1019

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$1,474,761,000	\$1,453,897,000
- STATE FUNDS	\$1,474,761,000	\$1,453,897,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,474,761,000	\$1,453,897,000
STATE FUNDS	\$1,474,761,000	\$1,453,897,000
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>
2011	\$100.77
2012	\$102.76
2013	\$103.70
2014	\$97.40
2015	\$97.65 (estimated)

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

BASE POLICY CHANGE NUMBER: 173

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 2010-11	\$1,049,777,643	1,113,792
FY 2011-12	\$1,367,279,250	1,150,028
FY 2012-13	\$1,454,929,918	1,176,313

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. The growth increase in the Medicare Part D PMPM for calendar year 2013 was 3.09% and Medi-Cal's PMPM increased to \$103.70.
2. The 2014 growth decreased 4.03 and Medi-Cal's estimated PMPM decreases to \$97.40.
3. The 2015 growth is assumed to increase 2.46% based on the average of annual percentage increase from Year 2011-2014 from *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM is \$97.65.
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 – August 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 2013-14</b>	12	1,209,843	\$122,896,779	<b>\$1,474,761,000</b>
<b>FY 2014-15</b>	12	1,242,850	\$121,158,091	<b>\$1,453,897,000</b>

**Funding:**

State Only General Fund (4260-101-0001)

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

**BASE POLICY CHANGE NUMBER:** 174  
**IMPLEMENTATION DATE:** 7/1990  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 23

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$1,236,319,000	\$1,297,385,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,236,319,000	\$1,297,385,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,236,319,000	\$1,297,385,000

**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 2013-14 have been revised to reflect updated data.

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

BASE POLICY CHANGE NUMBER: 174

**Methodology:**

1. The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)

	<b>Total Funds</b>	<b>CDDS GF</b>	<b>DHCS FFP</b>
<b>FY 2013-14</b>	\$2,472,637	\$1,236,318	<b>\$1,236,319</b>
<b>FY 2014-15</b>	\$2,594,772	\$1,297,386	<b>\$1,297,385</b>

**Funding:**

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

## DENTAL SERVICES

**BASE POLICY CHANGE NUMBER:** 175  
**IMPLEMENTATION DATE:** 7/1988  
**ANALYST:** Erickson Chow  
**FISCAL REFERENCE NUMBER:** 135

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$498,146,000</b>	<b>\$505,737,000</b>
<b>- STATE FUNDS</b>	<b>\$238,978,600</b>	<b>\$242,774,100</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>\$498,146,000</b>	<b>\$505,737,000</b>
<b>STATE FUNDS</b>	<b>\$238,978,600</b>	<b>\$242,774,100</b>
<b>FEDERAL FUNDS</b>	<b>\$259,167,400</b>	<b>\$262,962,900</b>

### 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. The Dental costs for new beneficiaries due to the Affordable Care Act (ACA) are included in the ACA policy changes.

**Reason for Change from Prior Estimate:**

Revised based on additional months of actual data from February 2013 through July 2013.

**Methodology:**

1. The capitation rates for FY 2012-13 are \$5.74 for regular eligibles and \$3.22 for refugees. These rates will remain in effect until new rates for FY 2013-14 have been approved. The new rates for FY 2013-14 will include separate rates for children and adults.
2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. Due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013, the next annual independent audit for the period of July 1, 2011 through June 31, 2013 will not be completed until FY 2014-15.

**DENTAL SERVICES**

BASE POLICY CHANGE NUMBER: 175

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.

<b>FY 2013-14</b>	<b>Rate</b>	<b>Average Monthly Eligibles</b>	<b>Total Funds</b>
Regular 7/13 – 6/14	\$5.74	6,495,129	\$451,585,000
Refugee 7/13 – 6/14	\$3.22	2,010	\$78,000
Other FFS	Non-Capitated		\$46,483,000
		Subtotal	\$498,146,000
Underwriting Gain/Loss			\$0
<b>FY 2013-14 Dental Total</b>			<b>\$498,146,000</b>

<b>FY 2014-15</b>	<b>Rate</b>	<b>Average Monthly Eligibles</b>	<b>Total Funds</b>
Regular 7/14 – 6/15	\$5.74	6,564,793	\$456,385,000
Refugee 7/14 – 6/15	\$3.22	2,013	\$78,000
Other FFS	Non-Capitated		\$49,274,000
<b>FY 2014-15 Dental Total</b>			<b>\$505,737,000</b>

<b>FY 2013-14</b>	<b>TF</b>	<b>FF</b>	<b>GF</b>
Title XIX 65/35	\$67,336,000	\$43,768,000	\$23,568,000
100% FFP	\$12,000	\$0	\$12,000
50/50 Title XIX	\$430,798,000	\$215,399,000	\$215,399,000
<b>Total</b>	<b>\$498,146,000</b>	<b>\$259,167,000</b>	<b>\$238,969,000</b>

<b>FY 2013-14</b>	<b>TF</b>	<b>FF</b>	<b>GF</b>
Title XIX 65/35	\$67,336,000	\$43,768,000	\$23,568,000
100% FFP	\$12,000	\$0	\$12,000
50/50 Title XIX	\$438,389,000	\$219,194,500	\$219,194,500
<b>Total</b>	<b>\$505,737,000</b>	<b>\$262,962,500</b>	<b>\$242,774,500</b>

**Funding:**

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

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

100% GF (4260-101-0001)

## DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

**BASE POLICY CHANGE NUMBER:** 176  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 77

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$258,500,000	\$263,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$258,500,000	\$263,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$258,500,000	\$263,000,000

### 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.

The General Fund (GF) is included in the CDDS budget on an accrual basis and 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.

**Methodology:**

1. The following estimates have been provided by CDDS.

**DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**

BASE POLICY CHANGE NUMBER: 176

<b>CASH BASIS</b> <b>(In Thousands)</b>	<b>Total</b> <b>Funds</b>	<b>CDDS</b> <b>GF</b>	<b>FFP</b> <b>Regular</b>	<b>Interagency</b> <b>Agreement</b>
<b>FY 2013-14</b>	\$517,000	\$258,500	<b>\$258,500</b>	03-75282 03-75283
<b>FY 2014-15</b>	\$526,000	\$263,000	<b>\$263,000</b>	03-75282 03-75283

**Funding:**

100% Title XIX (4260-101-0890)

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

**BASE POLICY CHANGE NUMBER:** 179  
**IMPLEMENTATION DATE:** 7/1991  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 26

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$145,524,000	\$154,922,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$145,524,000	\$154,922,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$145,524,000	\$154,922,000

### 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: 179

**Methodology:**

1. The following estimates have been provided by CDDS:

(In Thousands)

<b>CASH BASIS</b>	<b>Total Funds</b>	<b>CDDS GF</b>	<b>DHCS FFP</b>	<b>IA #</b>
<b>FY 2013-14</b>	\$291,048	\$145,524	<b>\$145,524</b>	03-75284
<b>FY 2014-15</b>	\$309,844	\$154,922	<b>\$154,922</b>	03-75284

**Funding:**

100% Title XIX (4260-101-0890)

## MEDI-CAL TCM PROGRAM

**BASE POLICY CHANGE NUMBER:** 180  
**IMPLEMENTATION DATE:** 6/1995  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 27

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$45,290,000	\$44,554,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,290,000	\$44,554,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$45,290,000	\$44,554,000

### 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:**

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

$$\$42,000,000 \text{ average expenditures} \times (1 + 2\% \text{ rate increase} + 2\% \text{ cost reconciliation}) = \$43,680,000$$
- Payments for FY 2011-12 and FY 2012-13 cost reconciliation will be made in FY 2013-14.
- The projected payment amount for FY 2014-15 was based on the FY 2013-14 estimated amount

**MEDI-CAL TCM PROGRAM****BASE POLICY CHANGE NUMBER: 180**

plus an increase of 2% for a rate increase. The FY 2014-15 reconciliation will be applied to the FY 2015-16 estimate.

<b>FY 2013-14</b>	<b>TF</b>	<b>FF</b>
2011-12	\$700,000	\$700,000
2012-13	\$910,000	\$910,000
2013-14	\$43,680,000	\$43,680,000
<b>Total</b>	<b>\$45,290,000</b>	<b>\$45,290,000</b>
<b>FY 2014-15</b>	<b>\$44,554,000</b>	<b>\$44,554,000</b>

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 181  
**IMPLEMENTATION DATE:** 4/2000  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 32

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$37,199,000	\$37,899,000
- STATE FUNDS	\$18,599,500	\$18,949,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$37,199,000	\$37,899,000
STATE FUNDS	\$18,599,500	\$18,949,500
FEDERAL FUNDS	\$18,599,500	\$18,949,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

AB 668 (Chapter 896, Statutes of 1998)

**Interdependent Policy Changes:**

PC 37 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 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: 181****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 2013-14 and FY 2014-15.
2. Assume the number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by one per month in FY 2013-14 and FY 2014-15.
3. The Department's CCT Demonstration Project expects to transition 365 beneficiaries out of inpatient extended health care facilities during FY 2013-14 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 2013-14 and FY 2014-15.

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)

## EPSDT SCREENS

**BASE POLICY CHANGE NUMBER:** 182  
**IMPLEMENTATION DATE:** 7/2001  
**ANALYST:** Yumie Park  
**FISCAL REFERENCE NUMBER:** 136

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$38,733,000	\$39,279,000
- STATE FUNDS	\$19,222,200	\$19,493,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$38,733,000	\$39,279,000
STATE FUNDS	\$19,222,200	\$19,493,250
FEDERAL FUNDS	\$19,510,800	\$19,785,750

### 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 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 2013-14 and FY 2014-15, based on a historical trend dating back to July 2008.

**FY 2013-14**

Screens 654,635 x \$59.17 (weighted average) = **\$38,733,000** (rounded)

**FY 2014-15**

Screens 663,396 x \$59.21 (weighted average) = **\$39,279,000** (rounded)

## EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 182

**Funding:**

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

Title XXI / GF (4260-113-0001/0890)

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 188  
**IMPLEMENTATION DATE:** 1/1993  
**ANALYST:** Raman Pabla  
**FISCAL REFERENCE NUMBER:** 91

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$2,446,000	\$2,571,000
- STATE FUNDS	\$1,223,000	\$1,285,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,446,000	\$2,571,000
STATE FUNDS	\$1,223,000	\$1,285,500
FEDERAL FUNDS	\$1,223,000	\$1,285,500

### 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 (e)  
 22 California Code of Regulations 50778 (Chapter 2, Article 15)

**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:**

Implementation of the ACA is anticipated to increase private health insurance premiums by 7.9% for FY 2013-14.

**Methodology:**

- The average monthly premium cost is estimated to be \$505.87 in FY 2013-14 and \$535.72 in FY 2014-15.
- The average monthly HIPP enrollment is estimated to be 403 in FY 2013-14 and 400 in FY 2014-15.

**HIPP PREMIUM PAYOUTS (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 188**

3. Costs for FY 2013-14 and FY 2014-15 are estimated to be:

**FY 2013-14:**  $\$505.87 \times 403 \times 12 \text{ Months} = \$2,446,000 \text{ TF } (\$1,223,000 \text{ GF})$

**FY 2014-15:**  $\$535.72 \times 400 \times 12 \text{ Months} = \$2,571,000 \text{ TF } (\$1,286,500 \text{ GF})$

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)

## LAWSUITS/CLAIMS

**BASE POLICY CHANGE NUMBER:** 189  
**IMPLEMENTATION DATE:** 7/1989  
**ANALYST:** Andrew Yoo  
**FISCAL REFERENCE NUMBER:** 93

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$2,496,000	\$1,865,000
- STATE FUNDS	\$1,248,000	\$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,496,000	\$1,865,000
STATE FUNDS	\$1,248,000	\$932,500
FEDERAL FUNDS	\$1,248,000	\$932,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

Not Applicable

**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:**

An additional lawsuit settlement.

## LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 189

**Methodology:**

	Committed FY 2013-14	Balance FY 2013-14	<b>Budgeted FY 2013-14</b>	<b>Budgeted FY 2014-15</b>
Attorney Fees <\$5,000	\$5,000	\$45,000	\$50,000 *	\$50,000 *
Provider Settlements <\$75,000	\$130,000	\$1,470,000	\$1,600,000 *	\$1,600,000 *
Beneficiary Settlements <\$2,000	\$1,000	\$14,000	\$15,000 *	\$15,000 *
Small Claims Court	\$1,000	\$199,000	\$200,000 *	\$200,000 *
Other Attorney Fees	\$475,000	N/A	\$475,000	\$0
Other Provider Settlements	\$0	N/A	\$0	\$0
Other Beneficiary Settlements	\$156,000	N/A	\$156,000	\$0
<b>Total</b>	<b>\$768,000</b>	<b>\$1,728,000</b>	<b>\$2,496,000</b>	<b>\$1,865,000</b>

\* Represents potential totals.

**Funding:**

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

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

**BASE POLICY CHANGE NUMBER:** 190  
**IMPLEMENTATION DATE:** 7/1997  
**ANALYST:** Joel Singh  
**FISCAL REFERENCE NUMBER:** 1083

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$1,799,000	\$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	\$1,799,000	\$1,285,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,799,000	\$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 matched 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: 190

**Methodology:**

1. Annual expenditures on the accrual basis are \$2,056,000. 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 2013-14</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<u>\$1,799</u>	<u>\$1,799</u>
<b>FY 2014-15</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<u>\$1,285</u>	<u>\$1,285</u>

**Funding:**

100% 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 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	-\$262,270,000	-\$255,248,000
- STATE FUNDS	-\$132,011,000	-\$128,477,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$262,270,000	-\$255,248,000
STATE FUNDS	-\$132,011,000	-\$128,477,000
FEDERAL FUNDS	-\$130,259,000	-\$126,771,000

### 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:**

Later actual recoveries show a slight increase over previously estimated. The General Fund ratio for collections was adjusted to exclude one-time events.

**Methodology:**

1. The recoveries estimate uses the trend in the monthly recoveries for July 2010 – July 2013.
2. The General Fund ratio for collections is estimated to be 50.33% in FY 2013-14 and FY 2014-15.

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

(Dollars in Thousands)

<b>Estimated Base Recoveries</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
Personal Injury Collections	(\$51,457)	(\$51,477)
Workers' Comp. Contract	(\$2,709)	(\$2,826)
H.I. Contingency Contract	(\$60,000)	(\$60,000)
General Collections	(\$148,104)	(\$140,945)
<b>TOTAL</b>	<b>(\$262,270)</b>	<b>(\$255,248)</b>

**Funding:**

100% GF (4260-101-0001)

50% GF / 50% Title XIX (4260-101-0001/0890)

## PROVIDER FRAUD IMPACT TO DMC PROGRAM

**BASE POLICY CHANGE NUMBER:** 203  
**IMPLEMENTATION DATE:** 8/2013  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1828

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	-\$14,650,000	-\$14,650,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$14,650,000	-\$14,650,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$14,650,000	-\$14,650,000

### DESCRIPTION

**Purpose:**

This policy change estimates the savings associated with the closure of Drug Medi-Cal (DMC) provider facilities that were suspended as a result of fraudulent Medi-Cal billing practices.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department performs various financial and medical audits as well as post-service, post payment utilization reviews to ensure Medi-Cal program integrity. Fraudulent Medi-Cal billing practices have been determined to have primarily occurred in the DMC Outpatient Drug Free Treatment Services program. The Department has taken significant steps to address fraud in the Drug Medi-Cal program.

A statewide enforcement sweep was launched in July. As of August, 30, 2013, the Department has issued temporary suspensions for 139 out of the 1,063 certified DMC providers and lodged 51 Credible Allegations of Fraud with the California Department of Justice for potential prosecution. The billings from these temporarily suspended providers totaled \$29.3 million of the \$162.4 million in approved DMC billings for FY 2012-13. This represents 18% of the expenditures of the program.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

1. The FY 2013-14 and FY 2014-15 estimate is based on suspended DMC payments for FY 2012-13.

**PROVIDER FRAUD IMPACT TO DMC PROGRAM**

BASE POLICY CHANGE NUMBER: 203

Cash Estimate	<b>TF</b>	<b>FFP Title XIX</b>	<b>FFP Title XXI</b>	<b>CF</b>
FY 2012-13	<u>\$29,300,000</u>	<u>\$14,357,000</u>	<u>\$293,000</u>	<u>\$14,650,000</u>
<b>TOTAL FY 2013-14</b>	<b>\$29,300,000</b>	<b>\$14,357,000</b>	<b>\$293,000</b>	<b>\$14,650,000</b>

Cash Estimate	<b>TF</b>	<b>FFP Title XIX</b>	<b>FFP Title XXI</b>	<b>CF</b>
FY 2013-14	<u>\$29,300,000</u>	<u>\$14,357,000</u>	<u>\$293,000</u>	<u>\$14,650,000</u>
<b>TOTAL FY 2014-15</b>	<b>\$29,300,000</b>	<b>\$14,357,000</b>	<b>\$293,000</b>	<b>\$14,650,000</b>

**Funding:**

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

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