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TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	1/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1511

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,195,670,000	$1,266,927,000
- STATE FUNDS	$418,484,500	$443,424,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,195,670,000	$1,266,927,000
STATE FUNDS	$418,484,500	$443,424,450
FEDERAL FUNDS	$777,185,500	$823,502,550

DESCRIPTION

Purpose:
This policy change estimates the benefits cost associated with transitioning the Healthy Families Program (HFP) subscribers into the Medi-Cal program.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:
CA 5 Transition of HFP to Medi-Cal
OA 2 CCS Case Management
OA 10 Transition of HFP to Medi-Cal
PC 73 Transition of HFP –SMH Services
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:
Effective January 1, 2013, HFP subscribers began a transition into Medi-Cal through a phase-in methodology. Children over 150% of the federal poverty level (FPL) will continue to be required to pay a premium for coverage. The administrative costs associated with this change are budgeted separately in the Transition of HFP to Medi-Cal policy changes under County Administration and Other Administration section of the Medi-Cal Estimate. In addition, postage and printing costs related to the transition are budgeted separately in the Health Care Option (HCO) section. All savings related to the Transition of HFP to Medi-Cal will be reflected in the Managed Risk Medical Insurance Board (MRMIB) budget.

Reason for Change from Prior Estimate:
In May, the final Phase was scheduled to transition in September. Now due to delays, some of the Phase 4 counties are scheduled to transition in November. Additionally, in May we did not account for current Medi-Cal populations shifting into the new targeted low income children (TLICP) groups. Combining the shifting Medi-Cal populations and the transitional children from HFP, the estimated

TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 1

caseload is higher than previously assumed in May. The higher caseload projections along with the updated Managed Care capitated rates have produced greater estimated costs for FY 2013-14.

Methodology:

1. Effective January 1, 2013, 871,027 HFP subscribers began transitioning to Medi-Cal through a phase-in methodology. This does not include 1,789 AIM infants with incomes between 250-300% FPL, which is budgeted separately in the AIM Linked Infants 250-300% FPL policy change. It is assumed the HFP caseload will experience 0.30% of annual growth in FY 2013-14 and FY 2014-15.

2. These eligibles are enrolled into managed care plans in those counties that have County Organized Health Systems, Geographic Managed Care, or the Two Plan Model.

3. The Transition of HFP subscribers into the Medi-Cal program occurs in four separate phases. The first phase was split into four groups transitioning January 1, 2013, March 1, 2013, April 1, 2013, and May 1, 2013 for all HFP subscribers currently enrolled in a managed care plan that also contracts directly with the Department. The second phase transitioned on April 1, 2013, for all HFP subscribers currently enrolled in a managed care plan that subcontracts with a Medi-Cal managed care plan. The third phase transitioned on August 1, 2013 for all HFP subscribers in a managed care county that were not transitioned in Phase 1 or Phase 2. The fourth phase was split into two phases transitioning September 1, 2013 and November 1, 2013, for all remaining HFP subscribers.

4. The weighted average monthly cost of benefits for these subscribers under the Medi-Cal program is estimated to be $87.63. This includes managed care capitation payments, FFS costs, managed care carve-outs, Federally Qualified Health Center (FQHC) wrap-around payments and dental payments (excluding California Children Services (CCS).

5. Premiums only will be assessed for subscribers over 150% of Federal Poverty Level (FPL) at the HFP Community Provider Plan (CPP) premium level. The Department will provide premium exemptions for children ages 0-1 years old, Alaska Natives, and American Indians regardless of income levels. In addition, the Department will offer 25% discounts for those subscribers who sign up for monthly electronic fund transfer (EFT), and those who pay three or more months in advance. Premiums are estimated to total $58,288,000 in FY 2013-14 and $59,455,000 in FY 2014-15.

6. Of the 871,027 subscribers, there are an estimated 23,381 CCS-HFP eligibles that will shift to CCS-Medi-Cal in FY 2013-14. The cost for these eligibles is currently budgeted in the Family Health Estimate. CCS-HFP is funded with 65% FFP, 21% GF, and 14% county funds. It is assumed that the county share will continue under Medi-Cal. The GF reimbursement from the counties for CCS-Medi-Cal is estimated to be $24,031,000 in FY 2013-14 and $30,534,000 in FY 2014-15.

7. Enhanced federal funding under Title XXI is available for these subscribers enrolled in Medi-Cal.

8. This policy change includes $15,601,000 TF ($5,460,000 GF) in FY 2013-14 and FY 2014-15 for benefit costs that were part of the Bridge to HFP policy change.

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TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 1

(In Thousands) **FY 2013-14**	**TF**	**GF**	**County Reimbursement***
Other Services	$1,066,709	$373,348	
CCS	$171,648	$36,046	$24,031
Bridge to HFP	$15,601	$5,460	
Benefits Total	$1,253,958	$414,854	$24,031
Premiums	($58,288)	($20,401)	
Net	**$1,195,670**	**$394,453**	**$24,031**

(In Thousands) **FY 2014-15**	**TF**	**GF**	**County Reimbursement***
Other Services	$1,092,681	$382,438	
CCS	$218,100	$45,801	$30,534
Bridge to HFP	$15,601	$5,460	
Benefits Total	$1,326,382	$433,699	$30,534
Premiums	($59,455)	($20,809)	
Net	**$1,266,927**	**$412,890**	**$30,534**

Funding:
65% Title XXI / 35% GF (4260-113-0890/0001)
100% Reimbursement (4260-610-0995)*

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FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	1/1997
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$632,717,000	$656,141,000
- STATE FUNDS	$158,474,900	$164,342,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$632,717,000	$656,141,000
STATE FUNDS	$158,474,900	$164,342,100
FEDERAL FUNDS	$474,242,100	$491,798,900

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
Actuals were lower than projected.

Methodology:
1. Use linear regressions on actual data from September 2010 to September 2013 for users, units per user, and dollars per unit.

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FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 2

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

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

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

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

	FY 2013-14		FY 2014-15	
Service Category	**TF**	**GF**	**TF**	**GF**
Physicians	$102,743,000	$25,734,000	$112,253,000	$28,116,000
Other Medical	$368,780,000	$92,367,000	$373,633,000	$93,583,000
County Outpatient	$3,330,000	$834,000	$3,636,000	$911,000
Community Outpatient	$4,879,000	$1,222,000	$4,932,000	$1,235,000
Pharmacy	$152,985,000	$38,318,000	$161,687,000	$40,497,000
Total	**$632,717,000**	**$158,475,000**	**$656,141,000**	**$164,342,000**

Funding:

(Dollars in Thousands)

FY 2013-14:

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$39,414	$19,707	$19,707
100% GF	4260-101-0001	$88,264	$88,264	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$505,039	$50,504	$454,535
Total		**$632,717**	**$158,475**	**$474,242**

FY 2014-15:

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$40,873	$20,437	$20,437
100% GF	4260-101-0001	$91,532	$91,532	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$523,736	$52,374	$471,362
Total		**$656,141**	**$164,343**	**$491,799**

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BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	1/2002
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	3

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$154,126,000	$163,528,000
- STATE FUNDS	$67,664,450	$71,429,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$154,126,000	$163,528,000
STATE FUNDS	$67,664,450	$71,429,650
FEDERAL FUNDS	$86,461,550	$92,098,350

DESCRIPTION

Purpose:
This policy change estimates the fee-for-service (FFS) costs of the Breast and Cervical Cancer Treatment Program (BCCTP).

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

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
Updated data; change in eligibles and PMPM.

Methodology:
1. There were 10,512 FFS and 2,817 managed care eligibles as of May 2013 (total of 13,329). 2,662 of the FFS eligibles were eligible for State-Only services.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

2. 595 of the FFS eligibles were in Accelerated Enrollment as of May 2013.

3. Assume the State will pay Medicare and other health coverage premiums for an average of 451 beneficiaries monthly in FY 2013-14 and FY 2014-15. Assume an average monthly premium cost per beneficiary of $251.09.

   FY 2013-14: 451 x $251.09 x 12 months = $1,358,000* TF ($1,358,000 GF) *Rounded
   FY 2014-15: 451 x $251.09 x 12 months = $1,358,000* TF ($1,358,000 GF) *Rounded

4. FFS costs are estimated as follows:

(In Thousands)	FY 2013-14		FY 2014-15	
	TF	GF	TF	GF
Federally Funded-Costs	$133,017	$46,556	$141,689	$49,591
State-Only Costs				
Services	$19,751	$19,751	$20,481	$20,481
Premiums	$1,358	$1,358	$1,358	$1,358
Total	**$154,126**	**$67,665**	**$163,528**	**$71,430**

5. Managed Care costs associated with the BCCTP are budgeted in the Two-Plan, County Organized Health Systems (COHS), and Geographic Managed Care (GMC) policy changes.

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

Funding:

(In Thousands)

FY 2013-14:		GF	FF	TF
General Fund	4260-101-0001	$21,109	$0	$21,109
Title XIX 35/65 FFP	4260-101-0001/0890	$46,556	$86,461	$133,017
Total		**$67,665**	**$86,461**	**$154,126**

FY 2014-15:		GF	FF	TF
General Fund	4260-101-0001	$21,839	$0	$21,839
Title XIX 35/65 FFP	4260-101-0001/0890	$49,591	$92,098	$141,689
Total		**$71,430**	**$92,098**	**$163,528**

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AIM LINKED INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	11/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1797

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$33,357,000	$33,357,000
- STATE FUNDS	$11,674,950	$11,674,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$33,357,000	$33,357,000
STATE FUNDS	$11,674,950	$11,674,950
FEDERAL FUNDS	$21,682,050	$21,682,050

DESCRIPTION

Purpose:
This policy change estimates the benefits cost to transition the Access for Infants and Mothers (AIM) linked infants with incomes between 250-300% into the Medi-Cal delivery system.

Authority:
AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective November 1, 2013, AIM Linked Infants will begin transitioning into the Medi-Cal delivery system through a phase-in methodology. Children who previously paid premiums with Managed Risk Medical Insurance Board (MRMIB) will continue paying premiums for coverage following the transition into the Medi-Cal delivery system.

Reason for Change from Prior Estimate:
The transition was delayed from October 1, 2013 to November 1, 2013.

Methodology:
1. Effective November 1, 2013, the Department estimates approximately 3,997 AIM Linked Infants with incomes between 250-300% FPL will transition into the Medi-Cal delivery system.

2. The Department assumes MRMIB will budget the costs for the AIM Linked Infants from July 1, 2013 through October 31, 2013.

3. MRMIB provided the estimated costs for FY 2013-14 and FY 2014-15 on a cash basis.

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AIM LINKED INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER: 4

(In Thousands)	TF	GF	FF
FY 2013-14	**$33,357**	**$11,675**	**$21,682**

(In Thousands)	TF	GF	FF
FY 2014-15	**$33,357**	**$11,675**	**$21,682**

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

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MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	4/2012
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1569

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$12,557,000	$10,827,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,557,000	$10,827,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$12,557,000	$10,827,000

DESCRIPTION

Purpose:
This policy change estimates the Federal Financial Participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR) and counties for the costs of providing inpatient services for inmates who are deemed eligible for Medi-Cal and health care services to former inmates who have been compassionately released or granted medical parole or medical probation.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)
SB 1462 (Chapter 837, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

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

SB 1399 authorizes the Board of Parole Hearings to grant medical parole to permanently medically incapacitated State inmates. State inmates granted medical parole are potentially eligible for Medi-Cal. When a state inmate is granted medical parole, CDCR submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through CDCR with 100% General Fund.

For State inmates, CDCR utilizes the Medi-Cal applications currently used by counties, and the Department makes an eligibility determination according to current standard eligibility rules. Federal Medicaid regulations and federal guidance allow states to cover inpatient services provided to otherwise Medicaid eligible inmates who receive such services off the ground of a correctional facility. The Department currently has an interagency agreement with CDCR in order to claim Title XIX FFP.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

SB 1462 authorizes a county sheriff, or his/her designee, to release certain prisoners (compassionate release) from a county correctional facility and request that a court grant medical probation, or resentencing in lieu of jail time, to certain county inmates. Counties are responsible for paying the non-federal share of costs associated with providing care to inmates compassionately released or granted medical probation. Counties are responsible for determining Medi-Cal eligibility for county inmates seeking medical probation or compassionate release.

Reason for Change from Prior Estimate:
Updated costs and eligibility percentages. In June 2013 we assumed that 100% of all county applications would be Medi-Cal recipients.

Methodology:

1. Implementation of coverage for the State inmates began April 2012. Implementation of coverage for county inmates began January 1, 2013.

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

3. Based on fee-for-service (FFS) and Managed Care cost data, the average cost for an inpatient admission is $9,640 for aged, $12,132 for disabled, $7,947 for LTC eligibles, and $10,660 for under 21.

4. Based on Managed Care delivery cost data, the average cost per event is $6,393 for delivery. Based on birth events data, 33% of the annual birth events will be for cesarean deliveries and 67% will be for vaginal deliveries.

5. It is assumed the Department will process 380 applications per month for State inmates with verified citizenship.

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

   380 monthly applications x 96% = 365 eligible State inmates

7. Of the 365 eligible State inmates, it is assumed 20% are for Medi-Cal and 80% are for LIHP. Of the Medi-Cal applications, it is assumed 75% are age 65 or older, 15% are disabled, 5% are for pregnancy events, and 5% are under 21 years of age.

Monthly Applications	FY 2013-14							FY 2014-15						
Aged	365	x	20%	x	75%	=	**55**	365	x	20%	x	75%	=	**55**
Disabled	365	x	20%	x	15%	=	**11**	365	x	20%	x	15%	=	**11**
Pregnancy Event	365	x	20%	x	5%	=	**4**	365	x	20%	x	5%	=	**4**
Under 21	365	x	20%	x	5%	=	**4**	365	x	20%	x	5%	=	**4**

8. State inmate inpatient costs are estimated to be $8,783,000 ($4,391,500 GF) in FY 2013-14 and FY 2014-15.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

FY 2013-14 & FY 2014-15							TF	FF
Aged	55	x	12	x	$9,640	=	$6,363,000	$3,181,500
Disabled	11	x	12	x	$12,132	=	$1,601,000	$800,500
Pregnancy Event	4	x	12	x	$6,396	=	$307,000	$153,500
Under 21	4	x	12	x	$10,660	=	$512,000	$256,000
Total							**$8,783,000**	**$4,391,500**

9. It is assumed the Department will process 34 Medi-Cal applications per month for county inmates with verified citizenship.

10. Of the 34 eligible county inmates, it is assumed 75% are age 65 or older, 10% are disabled, 10% are for pregnancy events, and 5% are under 21 years of age

Monthly Applications	FY 2013-14					FY 2014-15				
Aged	34	x	75%	=	**26**	34	x	75%	=	**25**
Disabled	34	x	10%	=	**3**	34	x	10%	=	**3**
Pregnancy Event	34	x	10%	=	**3**	34	x	10%	=	**3**
Under 21	34	x	5%	=	**2**	34	x	5%	=	**2**

11. Implementation of the County inmate inpatient program began January 1, 2013; however, the claims will not be reimbursed until February, 2014. County inmate inpatient costs are estimated to be $13,184,000 TF ($9,253,000 TF + $3,931,000 TF) in FY 2013-14.

FY 2013-14 (Rounded)							TF	FF
Aged	26	x	18	x	$9,640	=	$4,512,000	$2,256,000
Disabled	3	x	18	x	$12,132	=	$655,000	$327,500
Pregnancy Event	3	x	18	x	$6,396	=	$345,000	$172,500
Under 21	2	x	18	x	$10,660	=	$384,000	$192,000
Total							**$5,896,000**	**$2,948,000**

FY 2014-15							TF	FF
Aged	26	x	12	x	$9,640	=	$3,008,000	$1,504,000
Disabled	3	x	12	x	$12,132	=	$437,000	$218,000
Pregnancy Event	3	x	12	x	$6,396	=	$230,000	$130,500
Under 21	2	x	12	x	$10,660	=	$256,000	$128,000
Total							**$3,931,000**	**$1,965,000**

12. In FY 2013-14 and FY 2014-15, it is assumed the Department will process 25 applications annually for State Medical Parolees with verified citizenship. It is assumed these eligibles will receive long term care (LTC) services for nine months of continuous coverage.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

13. State Medical Parolees inpatient costs are estimated to be:

FY 2013-14

LTC Eligible Months		PMPM		TF	FF
263*	x	$7,947	=	**$2,090,000**	**$1,045,000**

FY 2014-15

LTC Eligible Months		PMPM		TF	FF
225	x	$7,947	=	**$1,788,000**	**$894,000**

*FY 2013-14 LTC eligible months include 12/13 on cash basis.

14. In FY 2013-14 and FY 2014-15, it is assumed there will be 100 applications annually for county inmates granted Compassionate Release. It is assumed these eligibles will receive long term care (LTC) services for nine months of continuous coverage.

15. Implementation of the County Compassionate Release Program began January 1, 2013; however, the claims will not be reimbursed until February 1, 2014. Total estimated costs for FY 2013-14 are:

FY 2013-14

LTC Eligible Months		PMPM		TF	FF
1050*	x	$7,947	=	**$8,344,500**	**$4,172,250**

FY 2014-15

LTC Eligible Months		PMPM		TF	FF
900	x	$7,947	=	**$7,152,000**	**$3,576,000**

*FY 2013-14 LTC eligible months include 12/13 on cash basis.

16. Total estimated Medi-Cal Inpatient Hospital Costs for Adults in FY 2013-14 and FY 2014-15 are:

(In Thousands-Rounded)

Summary	**FY 2013-14**		**FY 2014-15**	
State	**TF**	**FF**	**TF**	**FF**
Parole	$2,090	$1,045	$1,788	$894
Adults	$8,783	$4,392	$8,783	$4,392
Total	$10,873	$5,437	$10,571	$5,286
County				
Compassionate Release/Probation	$8,345	$4,172	$7,152	$3,576
Adults	$5,896	$2,949	$3,931	$1,966
Total	$14,241	$7,121	$11,083	$5,542
State/County Total	$25,114	**$12,557**	$21,654	**$10,827**

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

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	7/2008
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	8

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,937,000	$12,786,000
- STATE FUNDS	$4,177,950	$4,475,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,937,000	$12,786,000
STATE FUNDS	$4,177,950	$4,475,100
FEDERAL FUNDS	$7,759,050	$8,310,900

DESCRIPTION

Purpose:
This policy change estimates the cost of providing pre-enrollment (PE) into the Medi-Cal Program or the Optional Targeted Low Income Children's Program (OTLICP) for children who receive a Children's Health and Disability Program (CHDP) screening.

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

Interdependent Policy Changes:
Not Applicable

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

The Medi-Cal PE is part of the Medically Indigent Children aid category, which is incorporated in the base estimate.

Effective January 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. These children are the Optional Targeted Low-Income Children. All children receiving a screen through the CHDP Gateway program are pre-enrolled into either the Medi-Cal or OTLIC Program. DHCS continues to receive enhanced Title XXI funding for children enrolled in the OTLIC Program.

Reason for Change from Prior Estimate:
The per-member-per-month (PMPM) costs decreased for the OTLIC PE, increased for the Medi-Cal PE, and the estimated caseload for aid code 8X decreased in FY 2013-14 and increased in FY 2014-

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CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 6

15. The PMPM for OTLIC PE decreased from $221.71 to $218.88 and the PMPM for Medi-Cal PE increased from $216.29 to $232.39.

Methodology:

1. Based on June 2009 through July 2013 eligible data, there will be 511,397 children (54,536 OTLIC, 426,558 Medi-Cal, and 30,303 CHDP State-Only) in FY 2013-14 and 534,513 children (58,413 OTLIC, 446,421 Medi-Cal and 29,678 CHDP State-Only) in FY 2014-15 who will be screened through the Gateway.

2. Based on August 2012 through July 2013 cost data and May 2012 through April 2013 eligible data, the PMPM cost for OTLIC PE is $218.88.

3. Based on February 2012 through January 2013 cost data and April 2012 through March 2013 eligible data, the PMPM cost for Medi-Cal PE is $232.39.

4. The estimated FY 2013-14 and FY 2014-15 OTLIC and Medi-Cal PE costs are as follows:

FY 2013-14:	**Avg. Mo. Eligibles**	**TF**	**GF**
OTLIC PE (Aid Code 8X)	**4,545**	**$11,937,000**	**$4,178,000**
Medi-Cal PE (Aid Code 8W- in base estimate)	**35,547**	$99,129,000	$49,565,000
Total		$111,066,000	$53,743,000

FY 2014-15:	**Avg. Mo. Eligibles**	**TF**	**GF**
OTLIC PE (Aid Code 8X)	**4,868**	**$12,786,000**	**$4,475,000**
Medi-Cal PE (Aid Code 8W-in base estimate)	**37,202**	$103,745,000	$51,873,000
Total		$116,531,000	$56,348,000

Funding:

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

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	4/2013
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1755

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$6,467,000	$5,517,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,467,000	$5,517,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$6,467,000	$5,517,000

DESCRIPTION

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

Authority:
AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
AB 396 authorizes the Department, counties, and the CDCR to claim Federal Financial Participation (FFP) for inpatient hospital services provided to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county.

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

Reason for Change from Prior Estimate:
FY 2012-13 retroactive claims for the county juvenile inmate program were paid in FY 2013-14.

Methodology:
1. Implementation of coverage began January 1, 2013.

2. Applications for Medi-Cal will be processed by the Department if the applicant received off-site

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 7

inpatient or psychiatric related services.

3. Based on fee-for-service (FFS) cost data the average cost for a general acute care inpatient admission is $10,660 and $6,297 for an inpatient psychiatric admission for those under 21 years old.

4. It is assumed the Department will process 29 applications per month for State inmates and 99 applications per month for county inmates with verified citizenship.

5. Of the estimated monthly applications, it is assumed 80% are for psychiatric services and 20% are for inpatient services.

(Rounded)

State Inmates	**FY 2013-14 & FY 2014-15**				
Psychiatric Services	29	x	80%	=	**23**
Inpatient Services	29	x	20%	=	**6**

(Rounded)

County Inmates	**FY 2013-14 & FY 2014-15**				
Psychiatric Services	99	x	80%	=	**79**
Inpatient Services	99	x	20%	=	**20**

6. State juvenile inmates costs are estimated to be $2,505,000 TF ($1,252,500 GF) in FY 2013-14 and in FY 2014-15.

FY 2013-14							**TF**	**FF**
Psychiatric Services	23	x	12	x	$6,297	=	$1,738,000	$869,000
Inpatient Services	6	x	12	x	$10,660	=	$767,000	$383,500
Total							**$2,505,000**	**$1,252,500**

FY 2014-15							**TF**	**FF**
Psychiatric Services	23	x	12	x	$6,297	=	$1,738,000	$869,000
Inpatient Services	6	x	12	x	$10,660	=	$767,000	$383,500
Total							**$2,505,000**	**$1,252,500**

7. Implementation of the county juvenile inmate program began January 1, 2012; however, the claims were not reimbursed until FY 2013-14. County juvenile inmate costs are estimated to be $10,428,000 TF ($8,528,000 TF + $1,900,000 retroactive claims) in FY 2013-14.

(Rounded)

FY 2013-14							**TF**	**FF**
Retroactive Claims							$1,900,000	$950,000
Psychiatric Services	79	x	12	x	$6,297	=	$5,970,000	$2,985,000
Inpatient Services	20	x	12	x	$10,660	=	$2,558,000	$1,279,000
Total							**$10,428,000**	**$5,214,000**

8. Total estimated costs for Medi-Cal Inpatient Hospital and Psychiatric Services for Juvenile Inmates in FY 2014-15 are:

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 7

(Rounded)
FY 2014-15

Psychiatric Services	79	x	12	x	$6,297	=	$5,970,000	$2,985,000
Inpatient Services	20	x	12	x	$10,660	=	$2,558,000	$1,279,000
Total							**$8,528,000**	**$4,264,000**

9. Total estimated costs for Med-Cal Inpatient Hospital and Psychiatric Services for Juvenile Inmates in FY 2013-14 and FY2014-15 are:

(Rounded)	FY 2013-14		FY 2014-15	
Summary	**TF**	**FF**	**TF**	**FF**
State	$2,505,000	$1,252,500	$2,505,000	$1,252,500
County	$10,428,000	$5,214,000	$8,528,000	$4,264,000
Total	$12,933,000	**$6,466,500**	$11,033,000	**$5,516,500**

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

REFUGEES

REGULAR POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	7/1980
ANALYST:	Dee Britton
FISCAL REFERENCE NUMBER:	14

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,887,000	$6,475,000
- STATE FUNDS	$5,887,000	$6,475,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,887,000	$6,475,000
STATE FUNDS	$5,887,000	$6,475,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

Authority:
Interagency Agreement #12-10028

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

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

Reason for Change from Prior Estimate:
Updated refugee eligibles from previous estimate.

Methodology:
1. Total refugee expenditures to be reimbursed by CDPH are estimated to be $5,886,000 in FY 2013-14 and $6,476,000 in FY 2014-15.

REFUGEES

REGULAR POLICY CHANGE NUMBER: 8

Funding:
Reimbursements (4260-610-0995)

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MCHA VS. DHCS AND MRMIB

REGULAR POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	2/2013
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1735

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$540,000	$234,000
- STATE FUNDS	$270,000	$117,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	66.48 %	81.71 %
APPLIED TO BASE		
TOTAL FUNDS	$181,000	$42,800
STATE FUNDS	$90,500	$21,400
FEDERAL FUNDS	$90,500	$21,400

DESCRIPTION

Purpose:
This policy change estimates the benefits cost of enrolling children into Medi-Cal that were not previously identified as eligible when they were screened through the Single Point of Entry (SPE).

Authority:
Not Applicable

Interdependent Policy Changes:
PC 117 MCO Tax Managed Care Plans - Incr. Cap. Rates
PC 139 MCO Tax Managed Care Plans - Funding Adjustment
PC 140 MCO Tax Managed Care Plans

Background:
The Department uses the SPE to process joint applications that serve as an application for the Healthy Families Program (HFP) and a screening device for the Federal Poverty Level (FPL) Medi-Cal program. Maternal and Child Health Access (MCHA) contended in a lawsuit that the Department and the Managed Risk Medical Insurance Board (MRMIB) are legally required to use the joint application as an application for all Medi-Cal programs, not just the FPL program.

On December 6, 2010, the court issued its decision ruling in favor of the Department on all issues except that the State must screen for section 1931(b) Medi-Cal eligibility before enrolling children ages 6 to 18 in the HFP. On July 10, 2012, the San Francisco Superior Court issued an order enforcing writ concerning the 1931(b) screening. The Department had previously agreed to implement a screen at SPE to identify “deemed eligible” infants.

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. Additionally, the new screening process was implemented, and all applications submitted to SPE are sent to county eligibility workers for a Medi-Cal determination.

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

MCHA VS. DHCS AND MRMIB

REGULAR POLICY CHANGE NUMBER: 9

Methodology:

1. Assume that MRMIB will notify approximately 268,192 prior SPE applicants that they may be eligible for 1931(b) Medi-Cal coverage.

2. Assume that the responses to the MRMIB notifications will be received and processed during January, February, and March 2013.

3. Assume a 7.3% response rate will result in 19,578 responses.

4. Assume that 33% of the responses will qualify for 2 months of accelerated enrollment at a per-member-per-month (PMPM) cost of $71.55.

   19,578 responses * 33% qualify for AE * 2 months * $71.55 PMPM = $925,000

5. Due to payment lag factors, only $623,000 of the $925,000 accelerated enrollment costs will be paid in FY 2012-13. The remaining $302,000 is estimated to be paid in FY 2013-14.

6. It is estimated there will be additional accelerated enrollment costs in the amount of $10,000 in FY 2012-13 and $4,000 in FY 2013-14. Total accelerated enrollment costs are estimated to be $633,000 in FY 2012-13 and $306,000 in FY 2013-14.

7. Assume that of the respondents, 30% will provide the necessary documentation to make a determination of Medi-Cal 1931(b) eligibility and only 2% will be found eligible.

8. Assume that the average benefits PMPM cost is $162.89.

   19,578 responses * 30% provide documentation * 2% found eligible * $162.89 PMPM * 12 months = $230,000 annual ongoing cost

9. It is estimated there will be additional ongoing costs in the amount of $4,000. Total annual ongoing costs are estimated to be $234,000.

10. Applying partial year phase-in adjustments and appropriate payment lags, the costs are:

	FY 2013-14		FY 2014-15	
	TF	**GF**	**TF**	**GF**
Accelerated Enrollment	$306,000	$153,000	$0	$0
Ongoing Benefits	$234,000	$117,000	$234,000	$117,000
Total	**$540,000**	**$270,000**	**$234,000**	**$117,000**

Funding:

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

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COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1823

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$2,409,000
- STATE FUNDS	$0	$933,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,409,000
STATE FUNDS	$0	$933,000
FEDERAL FUNDS	$0	$1,476,000

DESCRIPTION

Purpose:
This policy change estimates the benefits cost to transition children in the County Health Initiative Matching Fund (CHIM) program into the Medi-Cal delivery system.

Authority:
SB 800 (Chapter 448, Statutes of 2013)
AB 495 (Chapter 648, Statutes of 2001)
SB 36 (Chapter 416, Statues of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
AB 495 (Chapter 648, Statutes of 2001) created the CHIM fund in the State Treasury for the purpose of matching Title XXI federal funding with county local funds received via intergovernmental transfers.

Currently, the CHIM program is in three counties (San Francisco, San Mateo, and Santa Clara) and is monitored by the Managed Risk Medical Insurance Board (MRMIB). To be eligible for the CHIM program, children must be under the age of 19 years old and have a household income between 251% and 400% of the federal poverty level. Effective July 1, 2014, children participating in the CHIM program will transition into the Medi-Cal delivery system.

Reason for Change from Prior Estimate:
This is a new policy change.

Methodology:
1. Effective July 1, 2014, children participating in the CHIM program will transition into the Medi-Cal delivery system.

2. The Department assumes MRMIB will budget the costs for the CHIM program in FY 2013-14.

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER: 10

3. MRMIB provided the estimated costs for FY 2014-15 on a cash basis.

(In Thousands)	TF	SF	FF
Title XXI FFP	$1,476		$1,476
Title XXI GF	$424	$424	
CHIM Fund	$509	$509	
FY 2014-15	**$2,409**	**$933**	**$1,476**

Funding:
Title XXI FFP (4260-113-0890)
Title XXI GF (4260-113-0001)
County Health Initiative Matching Fund (CHIM) (4260-113-3055)

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NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	12/1997
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	15

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$63,554,000	$63,554,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$63,554,000	$63,554,000
FEDERAL FUNDS	-$63,554,000	-$63,554,000

DESCRIPTION

Purpose:
This policy change is a technical adjustment to shift funds from Title XIX 50% federal financial participation (FFP) to 100% GF because the Department cannot claim FFP for nonemergency health care expenditures for New Qualified Immigrants (NQI).

Authority:
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code 14007.5

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

Reason for Change from Prior Estimate:
Addition of January-June 2013 data.

Methodology:
1. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of NQIs from January 2006 through June 2013, current year and budget year costs were projected.

2. Based on the historical pattern of FFS versus managed care nonemergency service expenditures for the period of June 2010 through July 2011 (19.27%), the managed care totals for current year and budget year were projected.

NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 11

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

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

5. The estimated FFP Repayment in FY 2013-14 and FY 2014-15:

(Dollars In Thousands)	**FY 2013-14**	**FY 2014-15**
FFS	$106,568	$106,568
Managed Care	$20,539	$20,539
Total	$127,017	$127,017
FFP Repayment	**$63,554**	**$63,554**

Funding:
100% Title XIX FFP (4260-101-0890)
100% GF (4260-101-0001)

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	12/1998
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	13

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$56,409,300	-$57,988,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$56,409,300	-$57,988,650
FEDERAL FUNDS	$56,409,300	$57,988,650

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable.

Background:
Based on the provisions of SB 903 and Section 1902(l)(3) of the federal Social Security Act (42 U.S.C. Sec 1396a(l)(3)), resources will not be counted in determining the Medi-Cal eligibility for children ages 1 to the month of their 6th birthday in the 133 percent program and ages 6 to the month of their 19th birthday in the 100% program. This change was implemented to help streamline the application process and to align Medi-Cal eligibility more closely with the Healthy Families Program (HFP).

Effective January 1, 2013, the Healthy Families Program ceased to enroll new applicants and began transitioning children to the Medi-Cal program as Optional Targeted Low-Income children (OTLIC). Children enrolled as Optional Low Income Children have family income above the Medi-Cal income limit up to 250 percent of the Federal Poverty Level. The OTLIC Program does not count resources.

Reason for Change from Prior Estimate:
The estimated total managed care capitation for aid codes 8P and 8R increased from $264,835,000 to $273,000,000 in FY 2013-14 and $272,700,000 to $281,000,000 in FY 2014-15. Correspondingly, the monthly estimated eligibles increased from 176,712 to 205,938 in FY 2013-14 and 179,413 to 210,978 in FY 2014-15.

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RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 12

Methodology:

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

2. Average monthly fee-for-service (FFS) eligibles, which are included in the base, are estimated to be 54,019 in FY 2013-14 and 55,201 in FY 2014-15. It is assumed total FFS expenditures will be $38,726,000 in FY 2013-14 and $39,573,000 in FY 2014-15.

3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 206,000 in FY 2013-14 and 211,000 in FY 2014-15. It is assumed total Managed Care expenditures will be $321,000,000 in FY 2013-14 and $330,000,000 in FY 2014-15.

4. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2013-14 and FY 2014-15.

Funding:

(Dollars in Thousands)

FY 2013-14		**GF**	**FF**	**TF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($188,031)	($188,031)	($376,062)
65 % Title XXI /35 % GF	4260-113-0001/0890	$131,622	$244,440	$376,062
Net Impact		**($56,409)**	**$56,409**	$0

FY 2014-15		**GF**	**FF**	**TF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($193,295)	($193,295)	($386,591)
65 % Title XXI /35 % GF	4260-113-0001/0890	$135,306	$251,284	$386,591
Net Impact		**($57,989)**	$57,989	$0

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CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	1/2011
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1371

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$8,901,500	-$8,901,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$8,901,500	-$8,901,500
FEDERAL FUNDS	$8,901,500	$8,901,500

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that federal financial participation (FFP) is available for immigrants designated as “Qualified Aliens” if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the US for less than five years and pays for nonemergency services with 100% State funds. Immigrants who are not Qualified Aliens are eligible for state funded full-scope Medi-Cal if they have a satisfactory immigration status. FFP is only available for eligible immigrants and Qualified Aliens under the five year bar for emergency and pregnancy related services.

CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens and specified lawfully present immigrants who are children or pregnant women regardless of their date of entry into the US. Effective April 1, 2009, the Department began claiming FFP for Qualified Alien pregnant women and children. In FY 2013-14, the Department expects to implement full-scope coverage for lawfully present pregnant women and children.

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

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

Methodology:

1. Title XXI funding of 65/35 FFP is available for 0 to 18 year olds and Title XIX funding of 50/50 FFP is available for 19 and 20 year olds and pregnant women.

2. Assume this estimate is consistent for both FY 2013-14 and FY 2014-15.

3. Children
   Based upon quarterly claiming reports for 2013, 35.20% of expenditures for NQA services are for non-emergency services.

   FFS:
   Special reports of expenditures for NQA children for 2011 services show fee-for-service (FFS) costs (including managed care carve-outs) of $9,787,000 for 0 to 18 year olds and $1,055,000 for 19 and 20 year olds.

   Non-emergency FFS expenditures for NQA children are:
   $9,787,000 x 35.20% non-emergency = $3,445,000 (0 to 18 year olds)
   $1,055,000 x 35.20% non-emergency = $371,000 (19 and 20 year olds)

   Managed Care:
   Special reports of NQA children managed care eligibles for calendar 2011 show 171,628 eligible months for 0 to 18 year olds and 14,594 for 19 and 20 year olds.

   The average capitation for the NQA children and pregnant women is assumed to be $118.94 PMPM.

   The non-emergency managed care expenditures for NQA children are:

   171,628 eligible months x $118.94 PMPM x 35.20% non-emergency = $7,185,000 (0 to 18 year olds)

   14,594 eligible months x $118.94 PMPM x 35.20 % non-emergency = $611,000 (19 and 20 year olds)

4. Pregnant Women
   Based on special reports of expenditures for pregnant women, 6.64% of expenditures for pregnant women are for non-pregnancy related services.

   FFS:
   Total FFS costs including managed care carve-outs for pregnant women are $34,926,000.

   The non-pregnancy related FFS expenditures for pregnant women are:
   $34,926,000 x 6.64% = $2,319,000

   Managed Care:
   Special reports of NQA pregnant eligibles for calendar year 2011 show 86,471 eligible months.

   The average capitation for pregnant women is assumed to be $118.94 PMPM.

   Non-pregnancy services = 86,471 eligible months x $118.94 PMPM x 6.64% = $683,000

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

	Title XIX (50/50)	Title XXI (65/35)
Children (0-18)		
FFS	$0	$3,445,000
Managed Care	$0	$7,185,000
Children (19-20)		
FFS	$371,000	$0
Managed Care	$611,000	$0
Pregnant Women		
FFS	$2,319,000	$0
Managed Care	$683,000	$0
Total (rounded)	$3,984,000	$10,630,000
GF	$1,991,000	$3,720,500
FFP	**$1,992,000**	**$6,909,500**

5. Total FFP of $8,901,500 offsets the General Fund cost of providing services to these eligibles.

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

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INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	11/2012
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1776

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$211,000	-$348,000
- STATE FUNDS	-$105,500	-$174,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	35.45 %	23.86 %
APPLIED TO BASE		
TOTAL FUNDS	-$136,200	-$265,000
STATE FUNDS	-$68,100	-$132,480
FEDERAL FUNDS	-$68,100	-$132,480

DESCRIPTION

Purpose:
This policy change estimates the savings from discontinuing inmates who are ineligible for Medi-Cal due to their incarceration.

Authority:
Welfare & Institutions Code, section 14053

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 established the Incarceration Verification Program (IVP) to improve the process of identifying individuals ineligible for Medi-Cal benefits due to incarceration. Improving verification and identification capabilities lowers program expenditures and yields cost savings through the discontinuance of ineligible beneficiaries. All identified inmates will lose eligibility for Medi-Cal; however, some will remain eligible in the Medi-Cal Inmate Eligibility program for inpatient care.

Reason for Change from Prior Estimate:
Additional discontinued Managed Care beneficiaries.

Methodology:
1. Savings for IVP is only for eligibles in Managed Care, since it is assumed that no expenditures exist for those in fee-for-service (FFS).

2. Based on monthly reports of IVP and California Department of Corrections and Rehabilitation Division of Juvenile Justice (CDCR-DJJ) matches, it is estimated that 95 managed care beneficiaries will be discontinued from Medi-Cal in FY 2013-14, and FY 2014-15.

3. Total managed care savings is estimated to be $211,000 TF in FY 2013-14, and $348,000 TF in FY

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 14

2014-15.

4. In FY 2013-14, it is estimated that 35.45% of the managed care savings is captured in the base trends. In FY 2014-15, it is estimated that 23.86% of the managed care savings is captured in the base trends.

FY 2013-14	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($211,000)**	35.45%	($75,000)

FY 2014-15	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($348,000)**	23.86%	($83,000)

5. Total estimated savings not in the base trends:

FY 2013-14	**TF**	**GF**
Total Savings	**($136,000)**	**($68,500)**

FY 2014-15	**TF**	**GF**
Total Savings	**($265,000)**	**($132,000)**

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

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PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	5/2011
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1738

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$7,682,000	-$10,725,000
- STATE FUNDS	-$3,841,000	-$5,362,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	92.05 %	83.83 %
APPLIED TO BASE		
TOTAL FUNDS	-$610,700	-$1,734,200
STATE FUNDS	-$305,360	-$867,120
FEDERAL FUNDS	-$305,360	-$867,120

DESCRIPTION

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

Authority:
Not Applicable

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

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

Since the launch of the pilot program, Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Federal is implemented statewide.

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PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER: 15

Reason for Change from Prior Estimate:
The Department expanded PARIS-Federal statewide.

Methodology:

1. Savings for PARIS-Federal is assumed for both Managed Care and fee-for-service (FFS).

2. Based on quarterly reports from August 2012 through May 2013, it is estimated 644 managed care and 105 FFS beneficiaries will be discontinued from Medi-Cal in FY 2013-14 and FY 2014-15.

3. Total managed care savings is estimated to be $1,943,000 TF in FY 2013-14, and $2,713,000 TF in FY 2014-15. Total FFS savings is estimated to be $5,739,000 TF in FY 2013-14 and $8,012,000 TF in FY 2014-15.

4. In FY 2013-14, it is estimated that 92.05% of the managed care and FFS savings is captured in the base trends. In FY 2014-15, it is estimated that 83.83% of the managed care and FFS savings is captured in the base trends.

FY 2013-14	Total Savings	% in Base	Savings in Base
Managed Care Savings	($1,943,000)	92.05%	($1,789,000)
FFS Savings	($5,739,000)	92.05%	($5,283,000)
Total	**($7,682,000)**		**($7,072,000)**

FY 2014-15	Total Savings	% in Base	Savings in Base
Managed Care Savings	($2,713,000)	83.83%	($2,274,000)
FFS Savings	($8,012,000)	83.83%	($6,716,000)
Total	**($10,725,000)**		**($8,990,000)**

5. Total estimated savings not in the base trends:

FY 2013-14	TF	GF
Managed Care Savings	($155,000)	($77,500)
FFS Savings	($456,000)	($228,000)
Total	**($611,000)**	**($305,500)**

FY 2014-15	TF	GF
Managed Care Savings	($439,000)	($219,500)
FFS Savings	($1,296,000)	($648,000)
Total	**($1,735,000)**	**($867,500)**

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

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PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	8/2011
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1632

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$3,790,000	-$3,790,000
- STATE FUNDS	-$1,895,000	-$1,895,000
PAYMENT LAG	0.9347	0.9361
% REFLECTED IN BASE	35.38 %	35.44 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,289,200	-$2,290,500
STATE FUNDS	-$1,144,590	-$1,145,240
FEDERAL FUNDS	-$1,144,590	-$1,145,240

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14124.11

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

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

Reason for Change from Prior Estimate:
The number of beneficiaries that will receive services from Veteran's Affairs instead of Medi-Cal increased from 56 to 93 per year.

Methodology:
1. The DHCS currently is operating PARIS-Veterans in 11 counties.

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

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 16

3. It is estimated program expenditures will be reduced for 93 veterans in FY 2013-14 and FY 2014-15, of which 39 will be managed care and 54 will be FFS. DHCS expects that savings will continue in the budget year through discontinuances, share of cost modifications, and cost avoidance by identifying Other Health Coverage (OHC).

4. Average savings on a PMPM basis will be $184.83 in FY 2013-14 and $181.28 in FY 2014-15.

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

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PARIS-INTERSTATE

REGULAR POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	10/2009
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1357

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$26,010,000	-$38,477,000
- STATE FUNDS	-$13,005,000	-$19,238,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	87.37 %	79.83 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,285,100	-$7,760,800
STATE FUNDS	-$1,642,530	-$3,880,400
FEDERAL FUNDS	-$1,642,530	-$3,880,410

DESCRIPTION

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

Authority:
Not Applicable

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

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

Since the launch of the pilot program, Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Interstate is implemented statewide.

PARIS-INTERSTATE

REGULAR POLICY CHANGE NUMBER: 17

Reason for Change from Prior Estimate:
The Department expanded PARIS-Interstate statewide.

Methodology:

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

2. Based on prior quarterly reports of PARIS-Interstate matches, it is estimated that 8,214 managed care beneficiaries will be discontinued from Medi-Cal in FY 2013-14, and 8,820 in FY 2014-15.

3. Total managed care savings is estimated to be $26,010,000 TF in FY 2013-14, and $38,477,000 TF in FY 2014-15.

4. In FY 2013-14, it is estimated that 87.37% of the managed care savings is captured in the base trends. In FY 2014-15, it is estimated that 79.83% of the managed care savings is captured in the base trends.

FY 2013-14	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($26,010,000)**	87.37%	($22,726,000)

FY 2014-15	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($38,477,000)**	79.83%	($30,715,000)

5. Total estimated savings not in the base trends:

FY 2013-14	**TF**	**GF**
Total Savings	**($3,284,000)**	($1,642,000)

FY 2014-15	**TF**	**GF**
Total Savings	**($7,762,000)**	($3,881,000)

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

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ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1789

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,609,318,000	$6,586,221,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,609,318,000	$6,586,221,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,609,318,000	$6,586,221,000

DESCRIPTION

Purpose:
This policy change estimates the costs of the Affordable Care Act (ACA) optional expansion of coverage to newly eligibles.

Authority:
ABX1 1 (Chapter 3, Statutes of 2013)
SBX1 1 (Chapter 4, Statutes of 2013)

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
PC 62 Narcotic Treatment Program
PC 63 Residential Substance Abuse Services
PC 64 Outpatient Drug Free Treatment
PC 65 Intensive Outpatient Services

Background:
Effective January 1, 2014, the 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 the 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 the uninsured. These new mandatory requirements will increase enrollment of the currently eligible but not enrolled population. Costs for the mandatory requirements are budgeted separately in the ACA Mandatory Expansion policy change.

A percentage of the Medi-Cal expansion population will need substance use disorder treatment services and/or mental health services. Expenditures for county mental health services are included in this policy change.

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 18

Reason for Change from Prior Estimate:
The Low Income Health Program (LIHP) caseload scheduled to transition on January 1, 2014 increased from 480,000 in the May Appropriation to 600,000. Costs previously estimated in PC 244 ACA Expansion-LTSS for Optional Expansion were shifted into this policy change. Lastly, this policy change added Short Doyle carve-outs related to specialty mental health (SMH) benefits provided through the county systems.

Methodology:

1. Effective January 1, 2014, the ACA will expand eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the FPL. The Department expects the overall population to result in a significant number of newly eligible Medi-Cal beneficiaries.

2. The Department utilized enrollment projections from the California Simulation of Insurance Markets (CalSIM Version 1.8) model designed by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center.

3. The Department estimates 691,389 newly eligible beneficiaries will enroll in Medi-Cal in FY 2013-14 and grow to 800,257 in FY 2014-15. The Department estimates 3,845 newly eligible beneficiaries who are not eligible for full scope coverage due to immigration status will receive restricted scope coverage in FY 2013-14 and 9,054 in FY 2014-15.

4. The Department estimates the LIHP population (600,000 eligibles) to transition on January 1, 2014.

5. In FY 2013-14, the estimated weighted average per-member-per-month (PMPM) for the newly eligible population is $428.04. The PMPM includes managed care capitation rates, managed care carve-outs, SMH carve-outs, and dental capitated rates.

6. The ACA requires Medi-Cal to increase the primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department receives 100% FFP for the additional incremental increase in Medi-Cal rates.

7. This policy change includes adjustments made for the Managed Care Organization (MCO) tax. The MCO tax fund (4260-601-3156) offsets the general fund (4260-101-0001).

8. The total estimated costs for the ACA optional expansion in FY 2013-14 and FY 2014-15 are:

(In Thousands)

FY 2013-14	**TF**	**GF**	**FF**
Newly Eligible Costs	$2,384,360	$0	$2,384,360
SMH carve-outs	$73,993	$0	$73,993
Long Term Support Services (LTSS)	$142,617	$0	$142,617
Restricted scope beneficiaries	$8,348	$0	$8,348
MCO Tax[1,2]	$0	($47,983)	$0
Total	**$2,609,318**	**($47,983)**	**$2,609,318**

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ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 18

FY 2014-15	TF	GF	FF
Newly Eligible Costs	$5,650,006	$0	$5,650,006
SMH carve-outs	$182,952	$0	$182,952
Long Term Support Services (LTSS)	$711,980	$0	$711,980
Restricted scope beneficiaries	$41,283	$0	$41,283
MCO Tax[1,2]	$0	($219,087)	$0
Total	**$6,586,221**	**($219,087)**	**$6,586,221**

Funding:

(In Thousands)

FY 2013-14:	TF	SF	FF
100% Title XIX Federal Share (4260-101-0890)	$2,609,318	$0	$2,609,318
[1]100% GF (4260-101-0001)	$0	($47,983)	$0
[2]MCO Tax Fund (4260-601-3156)	$0	$47,983	$0
Total	**$2,609,318**	**$0**	**$2,609,318**

FY 2014-15:	TF	SF	FF
100% Title XIX Federal Share (4260-101-0890)	$6,586,221	$0	$6,586,221
[1]100% GF (4260-101-0001)	$0	($219,087)	$0
[2]MCO Tax Fund (4260-601-3156)	$0	$219,087	$0
Total	**$6,586,221**	**$0**	**$6,586,221**

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	11/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1659

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,715,678,000	$603,211,000
- STATE FUNDS	$34,762,500	$27,246,000
PAYMENT LAG	0.9686	0.9987
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,661,805,700	$602,426,800
STATE FUNDS	$33,670,960	$27,210,580
FEDERAL FUNDS	$1,628,134,750	$575,216,250

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided for the incremental increase in rates from the 2009 Medi-Cal levels to 100% of Medicare for primary care physician (PCP) services provided from January 1, 2013 to December 31, 2014. This policy change also budgets the costs associated with the implementation of the increase payment.

Authority:
Section 1202 of the Affordable Care Act (ACA) (H.R. 4872, Health Care and Education Reconciliation Act of 2010)

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:
Section 1202 of the ACA requires Medi-Cal to increase primary care physician service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department will receive 100% FFP for the additional incremental increase in Medi-Cal rates determined using Medi-Cal rates that were in effect as of July 1, 2009 compared to the 2013 and 2014 Medicare rates.

The primary care service codes subject to ACA provisions are evaluation and management (E&M) codes: 99201-99499 and immunization administration procedure codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, and 90474. This provision extends to any subsequent modifications to the coding of these services.

The rate increase applies to primary care services furnished by physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine and subspecialists related to the primary care specialists, recognized in accordance with the American Board of Medical Specialties, American Board of Physician Specialties, and American Osteopathic Association. In addition, the rate

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 19

increase would apply to primary care services that are properly billed under the provider number of a physician who is enrolled as one of the specified primary care specialists, regardless of whether furnished by the physician directly or under the physician's personal supervision.

Reason for Change from Prior Estimate:

- The implementation date for the increase payments changed from July 1, 2013 to November 1, 2013 due to delay in expected federal approval and implementing necessary system changes.
- Increase in 100% FFP funds due to updated Medi-Cal fee-for-service (FFS) paid claims and managed care data.
- Decrease in AB 97 savings lost due to updated data to specify the eligible PCP services to be exempted from the payment reductions.

Methodology:

1. Implementation is expected to begin November 1, 2013, and the increase would be retroactive to January 1, 2013.

2. FY 2011-12 Medi-Cal FFS paid claims data for certain E&M and immunization administration procedure codes was used to study the Medi-Cal payment rate and utilization for each procedure code. Medicare cross-over and state-only paid claims were excluded from the data.

3. FY 2011-12 data includes the 1% payment reduction to physicians, that was implemented pursuant to AB 1183 (Chapter 758, Statutes of 2008), effective March 1, 2009.

4. Medicare rates for year 2014 are not available. As a result, for FY 2014-15, the 2013 Medicare Physician Fee Schedule was used to determine California's weighted average Medicare rate for each procedure code.

5. Based on the rate analysis, Medi-Cal payments to physicians for the selected procedure codes totaled $264,360,000 in FY 2011-12. Medi-Cal payments were determined to be at 46% of Medicare.

6. The incremental FFP needed to reach Medicare levels are estimated to be:

(In Thousands)	Annual FFP
FFS	$310,365
Managed Care	$749,835
Total	$1,060,200

7. Administrative costs for managed care plans to implement the increase payments are funded at the regular 50% Federal Medical Assistance Percentage (FMAP) and estimated to be $45,526,000 TF annually.

8. Some portion of the managed care capitation rates currently in place that were paid at 50% FMAP are eligible for 100% FMAP. The estimated General Fund (GF) reimbursement due to the adjustment is $37,235,000.

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PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 19

9. ACA payments for primary care services are exempt from AB 97 (Chapter 3, Statutes of 2011) payment reductions.

(Dollars in Thousands)

	Annual Savings Lost	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup	Total Recoupment Amounts (lagged)
FFS	$46,152	1/1/2013	1/9/2014	12	11/1/2014	66	$37,914
Managed Care	$45,350	1/1/2013	10/1/2013	N/A	N/A	N/A	N/A

10. The Department projects costs to raise rates for primary care services to the July 1, 2009 Medi-Cal levels to qualify for the enhanced federal funding are:

(In Thousands)	TF	GF
FY 2013-14	$125,377	$62,689
FY 2014-15	$73,110	$36,555

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 19

11. The estimated payments based on a cash basis are:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
FFS	$206,910	$0	$206,910
FFS Retro	$258,638	$0	$258,638
Managed Care	$499,890	$0	$499,890
Managed Care Retro	$624,863	$0	$624,863
Managed Care GF Reimbursement	$0	($27,926)	$27,926
Total Increase Payment	$1,590,301	($27,926)	$1,618,227
Managed Care Admin. Costs	$68,289	$34,145	$34,145
FFS (AB97 Savings Lost)	$23,076	$11,538	$11,538
Managed Care (AB97 Savings Lost)	$34,012	$17,006	$17,006
Total AB 97 Savings Lost	$57,088	$28,544	$28,544
Total	**$1,715,678**	**$34,763**	**$1,680,916**

FY 2014-15	**TF**	**GF**	**GF**
FFS	$155,183	$0	$155,183
FFS Retro	$0	$0	$0
Managed Care	$374,918	$0	$374,918
Managed Care Retro	$0	$0	$0
Managed Care GF Reimbursement	$0	($9,309)	$9,309
Total Increase Payment	$530,101	($9,309)	$539,410
Managed Care Admin. Costs	$22,763	$11,382	$11,382
FFS (AB97 Savings Lost)	$27,672	$13,836	$13,836
Managed Care (AB97 Savings Lost)	$22,675	$11,337	$11,337
Total AB 97 Savings Lost	$50,347	$25,173	$25,173
Total	**$603,211**	**$27,246**	**$575,965**

Funding:
100% Title XIX (4260-101-0890)
50% GF / 50% Title XIX (4260-101-0001/0890)
100% GF (4260-101-0001)

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COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	12/2012
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1595

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$238,923,000	$219,412,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$238,923,000	$219,412,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$238,923,000	$219,412,000

DESCRIPTION

Purpose:
This policy change budgets Title XIX federal funding for the Department of Social Services (CDSS) associated with the Community First Choice Option (CFCO).

Authority:
Welfare & Institutions Code 14132.956
Affordable Care Act (ACA) 2401

Interdependent Policy Changes:
Not Applicable

Background:
The ACA established a new State Plan option, which became available to states on October 1, 2010, to provide home and community-based attendant services and supports through CFCO. CFCO allows States to receive a 6% increase in federal match for expenditures related to this option. The state submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) which proposed moving federally eligible Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Option (IPO) program participants into CFCO. The Department budgets Title XIX FFP for the provision of IHSS Plus Option and PCSP services to Medi-Cal beneficiaries.

The State Plan Amendment (SPA) was approved on August 31, 2012 with an effective date of December 1, 2011.

The CFCO generates new federal funds and creates General Fund savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO. CMS released final regulations on May 7, 2012, amending eligibility criteria for CFCO.

Reason for Change from Prior Estimate:
The FY 2013-14 estimate was revised based on the 2013 third quarter invoice being paid in FY 2012-13 instead of FY 2013-14 as previously anticipated.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 20

Methodology:

1. It is assumed all eligible participants will enroll retroactively to December 1, 2011.
2. Assume billing for additional FFP will be retroactive to December 2011.
3. Assume costs will be retroactive to December 1, 2011.
4. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage (FMAP) rate of 6%.
5. The estimated costs were provided by CDSS on a cash basis.

Funding:

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

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ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER:	21
IMPLEMENTATION DATE:	10/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1785

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$222,825,000	$867,333,000
- STATE FUNDS	$103,754,350	$419,214,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$222,825,000	$867,333,000
STATE FUNDS	$103,754,350	$419,214,950
FEDERAL FUNDS	$119,070,650	$448,118,050

DESCRIPTION

Purpose:
This policy change estimates the costs of the Affordable Care Act (ACA) mandatory expansion of coverage to currently eligible but not enrolled beneficiaries.

Authority:
ABX1 1 (Chapter 3, Statutes of 2013)
SBX1 1 (Chapter 4, Statutes of 2013)

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
PC 62 Narcotic Treatment Program
PC 63 Residential Substance Abuse Services
PC 64 Outpatient Drug Free Treatment
PC 65 Intensive Outpatient Services

Background:
Effective January 1, 2014, the 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 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.

A percentage of the Medi-Cal expansion population will need substance use disorder treatment services and/or mental health services. Expenditures for Drug Medi-Cal and county mental health services are not included in this policy change.

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 21

Reason for Change from Prior Estimate:
The phase-in of eligibles in FY 2013-14 was updated.

Methodology:

1. Effective January 1, 2014, the ACA will simplify eligibility for several coverage groups (Children, Pregnant Women, and 1931(b)).

2. The Department expects the eligibility simplification and ACA outreach efforts to result in a significant number of currently eligible but not enrolled Medi-Cal beneficiaries becoming certified eligibles.

3. The Department estimates an additional 333,372 eligibles will enroll in Medi-Cal in FY 2013-14 and 551,912 in FY 2014-15. This increase includes those who are assumed to retain coverage through enrollment simplification, targeted low income children (TLICP) eligibles who were unenrolled previously, and others who are currently eligible but not enrolled.

4. In FY 2013-14, it is estimated the weighted average per-member-per-month (PMPM) for those currently eligible but not enrolled is $135.97 except for the TLICP eligibles. The estimated PMPM for TLICP eligible but not enrolled children is $93.04. Both PMPM costs include: managed care capitation rates, managed care carve-outs, and dental capitated rates. In FY 2014-15, the Department assumes a 5% inflation factor for the PMPM costs.

5. The Department assumes enrollment for the currently eligible but not enrolled population will begin October 1, 2013. The currently eligible but not enrolled population is assumed to phase-in over 6-months. Beginning January 1, 2014, the Department estimates enrollment will increase due to the implementation of many ACA enrollment simplification procedures. This population is assumed to phase-in evenly over 12-months.

6. The ACA requires Medi-Cal to increase the primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department will receive 100% FFP for the additional incremental increase in Medi-Cal rates.

7. The ACA requires the expansion of Foster Care Medicaid coverage to age 26. The Department estimates the costs from expanding coverage for the Foster Care beneficiaries will be $10,671,000 TF ($5,336,000 GF) in FY 2013-14 and $30,223,000 TF ($15,112,000 GF) in FY 2014-15.

8. Included in this policy change are adjustments made for managed care organization (MCO) taxes.

9. The total estimated costs for the ACA mandatory expansion are:

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ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 21

(Dollars in Thousands)	FY 2013-14		FY 2014-15	
Currently Eligible but Uninsured (0-64)	**TF**	**GF**	**TF**	**GF**
Adult population (19-64 years)	$137,437	$68,719	$564,315	$282,158
Percent of Poverty (0-18 years)	$18,547	$9,274	$76,152	$38,076
TLICP (0-18 years)	$7,949	$2,782	$32,636	$11,423
Subtotal	$163,933	$80,774	$673,103	$331,656
Dental Capitation	$6,050	$2,830	$24,840	$11,619
Managed Care Carve-Outs	$30,023	$14,815	$123,271	$60,828
100% of Medicare Primary Care Rates	$12,148	$0	$15,896	$0
Total	$48,221	$17,645	$164,007	$72,447
Foster Care Expansion	$10,671	$5,336	$30,223	$15,112
MCO Tax - Benefit to GF	$0	-$3,661	$0	-$14,326
Net Impact to State	**$222,825**	**$100,093**	**$867,333**	**$404,889**

Funding:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF/SF**	**FF**
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$200,116	$100,058	$100,058
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$10,561	$3,696	$6,865
100% Title XIX FFP (4260-101-0890)	$12,148	$0	$12,148
3156 MCO Tax (Non-GF) (4260-601-3156)	$3,661	$3,661	$0
100% Title XIX GF (4260-101-0001)	($3,661)	($3,661)	$0
Total	**$222,825**	**$103,754**	**$119,070**

FY 2014-15	**TF**	**GF/SF**	**FF**
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$808,080	$404,040	$404,040
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$43,357	$15,175	$28,182
100% Title XIX FFP (4260-101-0890)	$15,896	$0	$15,896
3156 MCO Tax (Non-GF) (4260-601-3156)	$14,326	$14,326	$0
100% Title XIX GF (4260-101-0001)	($14,326)	($14,326)	$0
Total	**$867,333**	**$419,215**	**$448,118**

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MENTAL HEALTH SERVICES EXPANSION

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	1/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1807

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$73,695,000	$300,000,000
- STATE FUNDS	$28,427,000	$119,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$73,695,000	$300,000,000
STATE FUNDS	$28,427,000	$119,000,000
FEDERAL FUNDS	$45,268,000	$181,000,000

DESCRIPTION

Purpose:
This policy change estimates the costs for adding non-specialty mental health services into Medi-Cal managed care plans, effective January 1, 2014. The policy change also estimates costs of Medi-Cal covering mental health group counseling in both managed care and fee-for-service.

Authority:
SBX1 1 (Chapter 4, Statutes of 2013)
Welfare & Institutions Code 14132.03 and 14189

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:
Currently, Medi-Cal covers certain specialty mental health services provided by county mental health plans. Other mental health services are provided through the Medi-Cal fee-for-service delivery system. SBX1 1 requires non-specialty mental health services to be provided by managed care plans, effective January 1, 2014. The Department intends to amend managed care contracts to shift these services to the managed care delivery system. In addition, SBX1 1 requires Medi-Cal to cover mental health services that are included in the essential health benefits package that the State adopted pursuant to Health & Safety Code, section 1367.005. Because that package includes group mental health counseling, Medi-Cal will extend coverage for these services through the managed care plans effective January 1, 2014. These changes affect the current Medi-Cal eligibles and the eligibles that are added as a result of the Affordable Care Act (ACA) mandatory and optional expansions.

Reason for Change from Prior Estimate:
Updated rates.

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MENTAL HEALTH SERVICES EXPANSION

REGULAR POLICY CHANGE NUMBER: 22

Methodology:
The following is the estimated cost in FY 2013-14 and FY 2014-15. The amount shown for FY 2014-15 is a placeholder reflecting approximate anticipated costs based on a current estimate from a contracted actuarial firm. The FY 2014-15 rates will be further refined as part of the overall FY 2014-15 rate process.

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
Managed Care Capitation Rates	$88,826	$35,993	$52,833
FFS Savings	-$15,131	-$7,566	-$7,565
Total	**$73,695**	**$28,427**	**$45,268**
FY 2014-15			
Managed Care Capitation Rates	$330,000	$134,000	$196,000
FFS Savings	-$30,000	-$15,000	-$15,000
Total	**$300,000**	**$119,000**	**$181,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX (4260-101-0890)

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ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS

REGULAR POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1792

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$24,252,000	$49,922,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,252,000	$49,922,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$24,252,000	$49,922,000

DESCRIPTION

Purpose:
This policy change estimates the Federal Financial Participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR) and counties for the cost of inpatient services for “newly eligible” inmates beginning January 1, 2014.

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily single, childless adults, at or below 138 percent of the federal poverty level (FPL). The Department expects this optional expansion population to result in a significant number of new Medi-Cal beneficiaries.

AB 1628 authorizes the Department, counties, and the CDCR to claim FFP for inpatient hospital services to Medi-Cal adult inmates in state and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county.

This policy change estimates the FFP provided to CDCR and the counties for the cost of inpatient services specifically for “newly eligible” inmates beginning January 1, 2014.

Reason for Change from Prior Estimate:
The FY 2013-14 estimated FFP decreased from the Appropriation. This is due to revised estimates of the state adult ACA inmate population. Additionally, estimated county adult ACA inmate populations were added to this policy change. The new county adult ACA inmates offset most of the estimated decline in the state adult ACA inmate population.

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ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS

REGULAR POLICY CHANGE NUMBER: 23

Methodology:

1. Implementation of coverage for the state inmates began April 2012. Implementation of coverage for county inmates began January 1, 2013.

2. Applications for Medi-Cal are processed by the Department or counties if the applicant received off-site inpatient related services.

3. Based on fee-for-service (FFS) MN-AFDC and PA-AFDC data, the average per-member-per-month (PMPM) cost for an inpatient admission is $9,444 in FY 2013-14 and $9,720 in FY 2014-15.

4. The Department estimates the state will process 304 applications per month for state inmates and the counties will process 142 applications for county inmates. All processed applications must have verified citizenship status.

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

   304 monthly applications x 96% = 292 eligible state inmates
   142 monthly applications x 96% = 136 eligible county inmates

6. Estimated Medi-Cal inpatient hospital costs for adult ACA inmates in FY 2013-14 and FY 2014-15 are:

FY 2013-14							**TF**	**FF**
State inmates	292	x	6	x	$9,444	=	$16,546,000	$16,546,000
County inmates	136	x	6	x	$9,444	=	$7,706,000	$7,706,000
Total	**428**						**$24,252,000**	**$24,252,000**

FY 2014-15							**TF**	**FF**
State inmates	292	x	12	x	$9,720	=	$34,058,000	$34,058,000
County inmates	136	x	12	x	$9,720	=	$15,863,000	$15,863,000
Total	**428**						**$49,922,000**	**$49,922,000**

Funding:

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

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	2/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1021

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$22,027,000	$19,477,000
- STATE FUNDS	$11,013,500	$9,738,500
PAYMENT LAG	0.8720	0.8742
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,207,500	$17,026,800
STATE FUNDS	$9,603,770	$8,513,400
FEDERAL FUNDS	$9,603,770	$8,513,400

DESCRIPTION

Purpose:
This policy change estimates the cost of rate add-ons for AB 1629 facilities.

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
AB 1489 (Chapter 631, Statutes of 2012)

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:
AB 1629 requires the Department to provide a rate adjustment, implement a facility-specific rate methodology, and impose a quality assurance (QA) fee for freestanding skilled nursing facilities level-B (NF-Bs), including adult subacute days. The rate methodology provides for facility-specific cost-based per diem payments for AB 1629 facilities based upon allowable audited costs and additional reimbursement for the projected Medi-Cal cost of complying with new state or federal mandates, referred to as “add-ons.” The AB 1629 program add-ons are negotiated on an annual basis, and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific per-diem rates. These new mandated costs are budgeted for separately, as it will take two years to be reflected in the regular facility specific reimbursement rates.

Reason for Change from Prior Estimate:
The changes are due to:

- Updated add-ons for FY 2013-14 and 2014-15.
- This policy change no longer includes the estimated costs of rate increases.
- Costs for 2013-14 add-ons were included in FY 2013-14 managed care capitation rates.

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AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER: 24

Methodology:

1. Implementation date for AB 1629 Add-Ons will be February 1, 2014 for the 2013-14 rate year and August 1, 2014 for 2014-15 rate year.

2. Effective January 2011, the California Department of Public Health (CDPH) mandated SNFs to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on to the rates to reimburse the facilities for the additional costs will be effective for the 2013-14 rate year.

3. Effective April 2012, CDPH is requiring providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on to the rates to reimburse the facilities for the additional costs will be effective for the 2013-14 rate year.

4. The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. A $0.22 add-on to the rate to reimburse facilities will be effective for the 2013-14 rate year, $0.11 for FY 2014-15.

5. Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An Elder Justice Act $0.01 add-on reimburses LTC facilities for compliance costs. This add-on will be effective for the 2013-14 rate year.

6. The Patient Protection and Affordable Care Act (ACA) assessed two new fees on employers providing health insurance, an annual reinsurance fee and a Patient-Centered Outcomes Research Trust Fund Fee (PCORI) per covered life. An add-on of $0.04 will be effective for the 2013-14 and 2014-15 rate years.

7. Effective March 23, 2013, the Patient Protection and Affordable Care Act (ACA) requires Skilled Nursing Facility (SNF) to implement a compliance and ethics program. An add-on of $0.66 will be provided to cover costs associated with implementing this program and will be effective for the 2013-14 and 2014-15 rate years.

8. The Health Insurance and Portability and Accountability Act (HIPAA) issued new regulations regarding the use of Electronic Fund Transfers (EFT) and Electronic Remittance Advice Delivery Systems (E-RADS). A $0.03 add-on will be provided for associated training costs and will be effective for the 2013-14 and 2014-15 rate years.

FFS	FY 2013-14	FY 2014-15
Informed Consent	$1,173,000	$235,000
Std Admin Agreement	$180,000	$36,000
FUTA	$1,984,000	$2,580,000
Elder Justice Act	$90,000	$18,000
ACA Reinsurance and PCORI	$361,000	$866,000
ACA Compliance Program	$5,953,000	$14,287,000
HIPAA EFT and E-RADS	$271,000	$649,000
FFS Total	$10,012,000	$18,671,000
Managed Care	$0	$806,000
Retroactive Add-Ons-FFS	$12,014,000	$0
Total*	**$22,027,000**	**$19,477,000**

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER: 24

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

*Amounts may differ due to rounding.

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ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1821

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$18,672,000	$78,784,000
- STATE FUNDS	$9,168,500	$37,749,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,672,000	$78,784,000
STATE FUNDS	$9,168,500	$37,749,500
FEDERAL FUNDS	$9,503,500	$41,034,500

DESCRIPTION

Purpose:
This policy change estimates the benefit costs for providing hospital presumptive eligibility (PE). Hospital PE is a required provision of the Affordable Care Act (ACA).

Authority:
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
The ACA requires the Department to give hospitals the option, as of January 1, 2014, to determine PE for Medicaid. A qualified hospital may elect to make PE determinations on the basis of preliminary information and according to policies and procedures established by the Department. An eligible beneficiary may receive full-scope Medi-Cal through Hospital PE for up to two months. The Department will permit PE under this provision for:

- Pregnant women;
- Infants and children under the age of 19;
- Parents and other caretaker relatives;
- Childless adults 19-64; and,
- Former foster care youth.

The Department expects many hospitals will participate. This policy change estimates the benefits costs for providing Hospital PE. There is a separate policy change (OA-26 ACA Hospital Presumptive Eligibility) which estimates the contract costs to develop a simplified application form, online application and system interfaces with MEDS.

Reason for Change from Prior Estimate:
This is a new policy change.

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ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 25

Methodology:

1. Effective January 1, 2014, the ACA simplifies eligibility for several coverage groups (Children, Pregnant Women, and 1931(b)).

2. The Department estimates Medi-Cal enrollment will increase by approximately 1,024,761 beneficiaries in FY 2013-14 and 1,352,169 in FY 2014-15 as result of both ACA expansions.

3. Based on experience with the CHDP Gateway Program, the Department estimates approximately 1.4% of the ACA expansion populations and currently eligible populations subject to the new modified adjusted gross income (MAGI) requirements will receive Hospital PE.

4. It is estimated 25,160 average monthly eligibles (between January and June 2014) will receive Hospital PE in FY 2013-14 and 31,574 in FY 2014-15.

5. It is estimated the weighted average per-member-per-month (PMPM) costs are $181.23 in FY 2013-14 and $207.93 in FY 2014-15.

6. Total estimated benefit costs in FY 2013-14 and FY 2014-15 are:

   FY 2013-14: 25,160 PE eligibles x 6 months x $123.69 PMPM (lagged) = **$18,672,000 TF costs**
   FY 2014-15: 31,574 PE eligibles x 12 months x $207.93 PMPM = **$78,784,000 TF costs**

Funding:

(In Thousands)	TF	GF	FF
FY 2013-14			
50% Title XIX / 50% GF (4260-101-0890/0001)	$18,337	$9,168	$9,169
100% Title XIX Federal Share (4260-101-0890)	$335	$0	$335
Total	**$18,672**	**$9,168**	**$9,504**
FY 2014-15			
50% Title XIX / 50% GF (4260-101-0890/0001)	$75,499	$37,749	$37,750
100% Title XIX Federal Share (4260-101-0890)	$3,285	$0	$3,285
Total	**$78,784**	**$37,749**	**$41,035**

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ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1793

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$14,493,000	$56,924,000
- STATE FUNDS	$5,254,000	$20,638,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,493,000	$56,924,000
STATE FUNDS	$5,254,000	$20,638,000
FEDERAL FUNDS	$9,239,000	$36,286,000

DESCRIPTION

Purpose:
This policy change estimates the benefit costs for newly eligible New Qualified Immigrants (NQI) populations beginning January 1, 2014.

Authority:
SBX1 1 (Chapter 4, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA) specified that federal financial participation (FFP) is not available for full-scope Medi-Cal services for most qualified nonexempt aliens during the first 5 years they are in the country. Currently, FFP is only available for emergency, children, and pregnancy services. California law requires that legal immigrants receive the same services as citizens and pays for other services with 100% State GF.

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 optional expansion population to result in a significant number of new Medi-Cal beneficiaries. Additionally, the ACA requires states to participate in health benefit exchanges, whether they establish their own, partner with other states in a multi-state exchange, or have a federal government administered exchange. The health benefit exchange will provide the public with the ability to purchase health coverage. Individuals with incomes below 400% FPL will be eligible for federal subsidies to help offset the monthly premium costs. California has developed a state-operated Health Benefit Exchange called Covered California, which opened to the public October 1, 2013. Covered California is available for citizens and legal residents to purchase health coverage.

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ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 26

This policy change estimates the benefit costs for newly eligible NQI adult populations beginning January 1, 2014. Beginning January 1, 2015, the Department will begin transitioning new NQI eligibles and the optional expansion childless adult NQIs from Medi-Cal into Covered California. The Department will cover all out-of-pocket expenditures that may occur by transitioning into Covered California. The cost avoidance impact for the State is reflected in the summary table below.

Reason for Change from Prior Estimate:
The wraparound of out-of-pocket expenditures for the transitioning NQI population will begin January 1, 2015. Previously, the Department estimated in the May Appropriation the wraparound would begin January 1, 2014.

Methodology:

1) Effective January 1, 2014, newly eligible NQI adult populations (childless adults with incomes between 0-138% FPL and parent/caretaker relatives with incomes between 101-138% FPL) will receive Medi-Cal coverage as part of the ACA optional expansion.

2) The Department estimates 3,060 NQI parent/caretaker relatives and 17,360 NQI childless adults will enroll in Medi-Cal during 2014. Both NQI adult populations are estimated to phase-in evenly over 12-months.

3) Effective January 1, 2015, all childless adult NQIs will begin transitioning into Covered California. The Department will cover all premiums, copayments, and any differences in benefits that may occur from transitioning into Covered California.

4) The Department estimates the benefit costs for the newly eligible NQI adult populations will be:

(Dollars in thousands)

Exchange related Costs:	**FY 2013-14**		**FY 2014-15**	
Newly Eligible NQI Childless Adults:	**TF**	**GF**	**TF**	**GF**
Premiums for 0-138%	$0	$0	$2,465	$894
Wraparounds 0-138%	$0	$0	$1,129	$409
Copays 0-138%	$0	$0	$4,008	$1,453
Subtotal	$0	$0	$7,603	$2,756
Medi-Cal related Costs:				
NQI Parents 101-138%:	$2,172	$787	$14,077	$5,103
Childless NQI Adults 0-138%:	$12,322	$4,467	$35,245	$12,778
Subtotal	$14,493	$5,254	$49,321	$17,881
Total DHCS Costs:	**$14,493**	**$5,254**	**$56,924**	**$20,638**
Medi-Cal related cost avoidance:				
Benefit cost avoidance 0-138%	$0	$0	($44,614)	($16,175)
Net Difference:	$14,493	$5,255	$12,310	$4,463

Funding:
100% Title XIX FFP (4260-101-0890) (emergency and pregnancy related services)
100% GF (4260-101-0001) (all other services)

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USPSTF GRADE A AND B RECOMMENDATIONS

REGULAR POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1812

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$9,673,000	$70,186,000
- STATE FUNDS	$3,711,000	$26,380,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,673,000	$70,186,000
STATE FUNDS	$3,711,000	$26,380,500
FEDERAL FUNDS	$5,962,000	$43,805,500

DESCRIPTION

Purpose:
This policy change estimates the costs of providing preventive services in accordance with the United States Preventive Services Task Force (USPSTF) Grade A and B recommendations.

Authority:
Affordable Care Act Section 4106
Pending State Plan Amendment

Interdependent Policy Changes:
PC 30 1% FMAP Increase for Preventative Services

Background:
Effective January 1, 2013, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% in Federal Medical Assistance Percentage (FMAP) for providing specified preventive services. Eligible preventive services are those assigned grade A or B by the USPSTF. For states to be eligible to receive the enhanced FMAP, they must cover the specified preventive services in their standard Medicaid benefit package and cannot impose copayments for these services.

California submitted a State Plan Amendment to receive the additional 1% in FMAP obligating the state to provide these services. The Department will ensure that they have appropriate codes or modifiers available for providers to utilize a crosswalk from those codes and modifiers to the USPSTF recommendations. To comply with the most recent recommendations, the Department is adding screening and counseling services for alcohol and substance misuse to the existing benefit package.

Reason for Change from Prior Estimate:
This is a new policy change.

Methodology:
1. Assume implementation date January 1, 2014.

2. Assume estimated percentage of current eligibles who visit a physician annually is 82.02% and 75%

USPSTF GRADE A AND B RECOMMENDATIONS

REGULAR POLICY CHANGE NUMBER: 27

of them receives a screen.

3. Assume 15.9% of the total population screened requires brief intervention.

4. Assume the provider participation will phase-in over 12 months, beginning January 1, 2014.

5. FFS:
   - Assume estimated annual caseload growth is 1%.
   - In FY 2013-14, assume the estimated screening cost is $24.00 and $96.00 for intervention with 5% inflation factor.

6. Managed Care: Estimated per-member-per–month (PMPM) is $0.60 for FY 2013-14 and $1.91 for FY 2014-15. The PMPM costs include screening and intervention costs.

7. Costs for the newly eligible adults due to ACA optional expansion are eligible for enhanced FMAP 100%.

8. Assume services provided to eligible beneficiaries under the current Medi-Cal and ACA mandatory expansion are paid at regular FMAP 50%. See the 1% FMAP Increase for Preventive Services policy change for the enhanced 1% FMAP savings.

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USPSTF GRADE A AND B RECOMMENDATIONS

REGULAR POLICY CHANGE NUMBER: 27

FY 2013-14

Managed Care	**TF**	**GF**	**FFP**
Screening & Intervention Costs			
ACA Optional Expansion	$2,251,000	$0	$2,251,000
ACA Mandatory Expansion & Medi-Cal Age 18-64	$6,660,000	$3,330,000	$3,330,000
Managed Care Total	$8,911,000	$3,330,000	$5,581,000
FFS			
Screening Costs			
Medi-Cal Age18-64	$466,000	$233,000	$233,000
Intervention Costs			
Medi-Cal Age18-64	$296,000	$148,000	$148,000
FFS Total	$762,000	$381,000	$381,000
Total	**$9,673,000**	**$3,711,000**	**$5,962,000**

FY 2014-15

Managed Care	**TF**	**GF**	**FFP**
Screening & Intervention Costs			
ACA Optional Expansion	$17,425,000	$0	$17,425,000
ACA Mandatory Expansion & Medi-Cal Age 18-64	$42,827,000	$21,414,000	$21,414,000
Managed Care Total	$60,252,000	$21,414,000	$38,839,000
FFS			
Screening Costs			
Medi-Cal Age18-64	$6,072,000	$3,036,000	$3,036,000
Intervention Costs			
Medi-Cal Age18-64	$3,862,000	$1,931,000	$1,931,000
FFS Total	$9,934,000	$4,967,000	$4,967,000
Total	**$70,186,000**	**$26,381,000**	**$43,806,000**

Funding:
100% Title XIX (4260-101-0890)
50% GF / 50%Title XIX (4260-101-0001/0890)

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ACA DELAY OF REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1822

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$6,653,000	$668,000
- STATE FUNDS	$2,052,850	$205,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,653,000	$668,000
STATE FUNDS	$2,052,850	$205,800
FEDERAL FUNDS	$4,600,150	$462,200

DESCRIPTION

Purpose:
This policy change estimates the costs of delaying redeterminations for select currently enrolled Affordable Care Act (ACA) beneficiaries subject to the new modified adjusted gross income (MAGI) standards. This delay only impacts those beneficiaries scheduled to receive a redetermination between January 1, 2014 and March 31, 2014.

Authority:
SB 28 (Chapter 442, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the 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 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.

Beginning January 1, 2014, the Department will postpone redeterminations for 3-months for Medi-Cal beneficiaries who, under the new ACA rules, will be subject to the MAGI standard. This 3-month delay assists counties with additional time in order to process the new incoming ACA expansion beneficiaries.

Reason for Change from Prior Estimate:
This is a new policy change.

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ACA DELAY OF REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER: 28

Methodology:

1. Beginning January 1, 2014, the Department will delay redeterminations until April 1, 2014 for current Medi-Cal beneficiaries subject to the new MAGI standard. The Department assumes all delayed redeterminations will be complete no later than June 30, 2013.

2. The Department estimates there are 1,416,934 current Medi-Cal beneficiaries scheduled to receive their redetermination during the 3-month period.

3. Referencing a study from UCLA Center for Health Policy Research and the UC Berkeley Labor Center (2013) on Medi-Cal enrollment channels, the Department assumes 1.5% of the monthly Medi-Cal caseload will not maintain coverage for an entire year. Therefore, the Department assumes this will increase Medi-Cal enrollment temporarily with ineligible beneficiaries during the 3-month delay.

4. The Department estimates the increase in Medi-Cal enrollment during the 3-month period, will result in 37,309 additional ineligible member months. The average PMPM during this period is estimated to be $196.22.

5. Total estimated (unlagged) costs related to the delay in redeterminations is:
   37,309 additional member months x $196.22 PMPM = $7,321,000 TF (unlagged)

6. Because of the weighted fee-for-service payment lag between the service date and when a FFS claim is paid, the impact of the delay is realized in both FY 2013-14 and FY 2014-15:
   $7,321,000 x .9088 weighted FFS payment lag = **$6,653,000** TF cost in FY 2013-14
   $7,321,000 - $6,653,000 = **$668,000** TF cost in FY 2014-15

Funding:

FY 2013-14	**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$3,979,000	$1,989,500	$1,989,500
65% Title XXI FFP / 35% GF (4260-113-0890/0001)	$181,000	$63,000	$118,000
100% Title XIX ACA FFP (4260-113-0890)	$2,493,000	$0	$2,493,000
Total	**$6,653,000**	**$2,052,500**	**$4,600,500**

FY 2014-15	**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$399,000	$199,500	$199,500
65% Title XXI FFP / 35% GF (4260-113-0890/0001)	$18,000	$6,000	$12,000
100% Title XIX ACA FFP (4260-113-0890)	$251,000	$0	$251,000
Total	**$668,000**	**$205,500**	**$462,500**

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STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	7/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1802

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$796,000	$0
- STATE FUNDS	$796,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$796,000	$0
STATE FUNDS	$796,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the benefit costs related to extending Medi-Cal coverage to former foster care youth who will turn 21 years old between July 1, 2013 and December 31, 2013.

Authority:
AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:
CA 8 State-Only Former Foster Care Program

Background:
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). Additionally, the ACA requires the expansion of Foster Care Medicaid coverage to age 26, beginning January 1, 2014.

Effective July 1, 2013, the Department is changing the age-out policy for former foster youth currently receiving Medi-Cal benefits. Prior to July 1, 2013, once a former foster youth turned 21 years old they would lose their Medi-Cal coverage. Instead under the new policy, those scheduled to lose their Medi-Cal coverage between July 1, 2013 and December 31, 2013 will remain eligible to receive Medi-Cal benefits. These costs will be funded at 100% State General Fund.

Reason for Change from Prior Estimate:
The payment lag factors were updated.

Methodology:
1. The Department is extending Medi-Cal benefits to former foster youth who will turn 21 years old between July 1, 2013 and December 31, 2013.

2. The Department estimates 993 former foster youth will turn 21 years old between July 1, 2013 and December 31, 2013.

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER: 29

3. In FY 2013-14, the total estimated benefit costs are:

(Dollars in Thousands)	TF	GF	FF
FY 2013-14 costs	**$796**	**$796**	**$0**

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

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1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1791

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$40,284,000	-$26,950,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$40,284,000	-$26,950,000
FEDERAL FUNDS	$40,284,000	$26,950,000

DESCRIPTION

Purpose:
This policy change estimates the savings from receiving an additional 1% in federal medical assistance percentage (FMAP) for specified preventive services effective January 1, 2013.

Authority:
Affordable Care Act, Section 4106
AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. Eligible preventive services are those assigned grade A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). For states to be eligible to receive the enhanced FMAP, they must cover the specified preventive services in their standard Medicaid benefit package and cannot impose copayments for these services. The Department will incorporate new recommended Grade A and B preventative services to the existing Medi-Cal benefit package. AB 82 prohibits copayments for preventative services. The Department will report state expenditures eligible for the additional 1% FMAP on the revised CMS 64.

Reason for Change from Prior Estimate:
The changes are due to:

- Program effective date change from January 1, 2014 to January 1, 2013 according to the federal regulation, and
- Updated program expenditure amounts.

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1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 30

Methodology:

1. 1% FMAP savings is effective January 1, 2013.

2. Assume implementation date January 1, 2014.

3. Retroactive savings for period January 1, 2013 to December 31, 2013 will occur in FY 2013-14.

(Dollars In Thousands)

FY 2013-14	**TF**	**GF**	**FFP**
FFS	$0	($2,508)	$2,508
Managed Care	$0	($10,925)	$10,925
Retroactive Savings	$0	($26,851)	$26,851
Total	**$0**	**($40,284)**	**$40,284**

FY 2014-15	**TF**	**GF**	**FFP**
FFS	$0	($5,099)	$5,099
Managed Care	$0	($21,851)	$21,851
Total	**$0**	**($26,950)**	**$26,950**

Funding:

100% Title XIX (4260-101-0890)
100% GF (4260-101-0001)

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RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	1/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1742

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$18,000	-$112,000
- STATE FUNDS	-$9,000	-$56,000
PAYMENT LAG	0.5850	0.8770
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$10,500	-$98,200
STATE FUNDS	-$5,260	-$49,110
FEDERAL FUNDS	-$5,260	-$49,110

DESCRIPTION

Purpose:
This policy change estimates the savings identified by a Recovery Audit Contractor (RAC).

Authority:
Affordable Care Act (ACA), Section 6411(a)
SB 1529 (Chapter 797, Statutes of 2012)

Interdependent Policy Changes:
OA 57 Recovery Audit Contractor Costs

Background:
Section 6411(a) of the ACA requires states to contract with one or more RACs for the purpose of auditing Medicaid claims, identifying underpayments and overpayments, recouping overpayments, and educating providers. The Department awarded Health Management Systems, Inc. (HMS) this contract in April 2012. The contractor will receive 12.5% of the amount identified and recovered. The recovery audit contractor costs are budgeted in the Recovery Audit Contractor Costs policy change. The contract was approved in April 2013.

The four provider types identified for RAC audit are Optometrists, Podiatrists, Non-emergency medical transportation and Speech Therapists. The combined billing for these providers for the past three years is $12,506,375. HMS estimates 1% is recoverable from their automated system.

Reason for Change from Prior Estimate:
The changes are due to:

- Lower annual savings than anticipated, and
- Estimated 1% recovery rate.

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RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 31

Methodology:

1. Assume annual identified overpayment billing $12,506,375.

   $12,506,375 x 1% recovery rate = $125,000 annual savings (rounded)

2. Savings will be phased in over 12 months beginning January 2014. Until the phase in is complete, assume $868 in monthly savings starting January 2014 and an additional $868 each month thereafter.

   $125,000 annual savings ÷ 12 months ÷ 12 month phase-in = $868 monthly phase-in

	TF	GF	FF
FY 2013-14	**($18,000)**	**($9,000)**	**($9,000)**
FY 2014-15	**($112,000)**	**($56,000)**	**($56,000)**

Funding:

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

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PRIVATE DSH REPLACEMENT PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	10/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1747

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$15,687,000	-$17,113,000
- STATE FUNDS	-$7,843,500	-$8,556,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$15,687,000	-$17,113,000
STATE FUNDS	-$7,843,500	-$8,556,500
FEDERAL FUNDS	-$7,843,500	-$8,556,500

DESCRIPTION

Purpose:
This policy change estimates the reductions to private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005)
Affordable Care Act (ACA), H.R. 3590, Section 2551 and H.R. 4872, Section 1203

Interdependent Policy Changes:
PC 87 MH/UCD & BTR —Private Hospital DSH Replacement

Background:
The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) and California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) made changes to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, pursuant to SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The Department determines the payments using the formulas and methodology previously in effect in FY 2004-05. These replacement payments, along with $160.00 of the annual DSH allotment, satisfy the State's payment obligations under the Federal DSH statute. See the MH/UCD & BTR — Private Hospital DSH Replacement policy change for more information.

The ACA requires the nationwide reduction of State DSH allotments. The DSH allotment reduction begins in FY 2013-14 and the Centers for Medicare and Medicaid Services (CMS) will determine the amount of the reduction for each state.

The DSH allotment reduction affects DSH Replacement payments for private hospitals because, as required by SB 1100, the private DSH replacement payment methodology is dependent on the DSH allotment itself. Therefore, when the DSH allotment is reduced, the private DSH replacement payments will also be reduced.

PRIVATE DSH REPLACEMENT PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 32

The federal share of the private DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

Reason for Change from Prior Estimate:
The change is due to updated 2013-14 DSH allotment data from CMS. The prior estimate applied a nationwide percentage reduction based on the latest available DSH allotment; the DHS allotment prior to and after the ACA reduction was $1.51 billion and $1.01 billion, respectively. In this estimate, the 2013-14 DSH replacement aggregate is calculated based on an estimated DSH allotment prior to and after the ACA reduction of $1.167 billion and $1.134 billion, respectively.

Methodology:

1. California's estimated 2013-14 DSH allotment will be reduced by $32.6 million as published by CMS in the Federal Register, Vol. 78, No. 94 on May 15, 2013.

2. The reduced DSH allotment amount is applied in the DSH payment methodology to determine the reduction amount for the estimated 2013-14 aggregate DSH replacement funding. That amount is estimated to be $17.11 million TF, a reduction from $525.37 million to $508.26 million.

3. Assume 11/12 of the 2013-14 ACA DSH replacement reduction ($15.69 million TF) will occur in FY 2013-14 and 1/12 of the 2013-14 ACA DSH replacement reduction ($1.43 million TF) will occur in FY 2014-15.

4. The reduced 2014-15 DSH allotment is assumed to be the same as the reduced 2013-14 DSH allotment. That amount is estimated to be $17.11 million, a reduction from $535.87 million to $518.76 million.

5. Assume 11/12 of the 2014-15 DSH replacement reduction ($15.69 million TF) will occur in FY 2014-15.

The aggregate DSH replacement will be reduced as follows on a cash basis:

	TF	GF	FF
FY 2013-14			
DSH 2013-14	**($15,687,000)**	**($7,843,500)**	**($7,843,500)**
FY 2014-15			
DSH 2013-14	($1,426,000)	($713,000)	($713,000)
DSH 2014-15	($15,687,000)	($7,843,500)	($7,843,500)
Total	**($17,113,000)**	**($8,556,500)**	**($8,556,500)**

Funding:
50% GF / 50% Title XIX FF (4260-101-001/0890)

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DISPROPORTIONATE SHARE HOSPITAL REDUCTION

REGULAR POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	10/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1733

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$43,634,000	-$47,601,000
- STATE FUNDS	-$13,730,000	-$14,978,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$43,634,000	-$47,601,000
STATE FUNDS	-$13,730,000	-$14,978,000
FEDERAL FUNDS	-$29,904,000	-$32,623,000

DESCRIPTION

Purpose:
This policy change estimates the reductions to Disproportionate Share Hospitals (DSHs), as required under the Affordable Care Act (ACA).

Authority:
Affordable Care Act (ACA), H.R. 3590, Section 2551 and H.R. 4872, Section 1203

Interdependent Policy Changes:
PC 85 MH/UCD & BTR —DSH Payment

Background:
The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) and California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) made changes to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, under State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The General Fund, certified public expenditures (CPEs), or intergovernmental transfers (IGTs) funds the non-federal share of the payment. See the MH/UCD & BTR —DSH Payment policy change for more information.

The ACA requires the aggregate, nationwide reduction of State DSH allotments in the amount of $500 million for FY 2013-14 and $600 million for FY 2014-15. Reductions increase for each fiscal year through FY 2019-20. The reduced DSH allotment for each state will be determined by the Centers for Medicare & Medicaid Services (CMS).

Reason for Change from Prior Estimate:
The change is due to updated 2013-14 DSH allotment data from CMS. The prior estimate applied a nationwide percentage reduction based on the latest available DSH allotment; the DHS allotment prior to and after the ACA reduction was $1.51 billion and $1.01 billion, respectively. In this estimate, the 2013-14 DSH payment aggregate is calculated based on an estimated DSH allotment prior to and after the ACA reduction of $1.167 billion and $1.134 billion, respectively.

DISPROPORTIONATE SHARE HOSPITAL REDUCTION

REGULAR POLICY CHANGE NUMBER: 33

Methodology:

1. California's DSH allotment prior to the ACA reduction for FY 2013-14 and FY 2014-15 is estimated to be $1.167 billion as published by CMS in the Federal Register, Vol. 78, No. 94 on May 15, 2013.

2. The FY 2013-14 and FY 2014-15 DSH allotments after the reduction is estimated to be $1.134 billion as published by CMS in the Federal Register, Vol. 78, No. 94 on May 15, 2013.

3. Assume 11/12 of the FY 2013-14 DSH allotment reduction ($29.9 million) is expected to occur in FY 2013-14. The remaining 1/12 of the FY 2013-14 DSH allotment reduction ($2.7 million) is expected to occur in FY 2014-15.

4. Assume 11/12 of the FY 2014-15 DSH allotment reduction ($29.9 million) is expected to occur in FY 2014-15.

The aggregate DSH payment will be reduced as follows on a cash basis:

FY 2013-14	**TF**	**GF****	**FF**	**IGT***
DSH 2013-14	**($43,634,000)**	**($275,000)**	**($29,904,000)**	**($13,455,000)**
FY 2014-15				
DSH 2013-14	($3,967,000)	($25,000)	($2,719,000)	($1,223,000)
DSH 2014-15	($43,634,000)	($275,000)	($29,904,000)	($13,455,000)
Total	**($47,601,000)**	**($300,000)**	**($32,623,000)**	**($14,678,000)**

Funding:

100% Demonstration DSH Fund (4260-601-7502)
50% MIPA Fund / 50% Title XIX (4260-606-0834/0890)*
50% GF / 50% Title XIX (4260-101-0001/0890)**

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MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	4/2013
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1585

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$388,347,000	-$292,429,000
- STATE FUNDS	-$194,173,500	-$146,214,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$388,347,000	-$292,429,000
STATE FUNDS	-$194,173,500	-$146,214,500
FEDERAL FUNDS	-$194,173,500	-$146,214,500

DESCRIPTION

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

Authority:
Social Security Act Section 1927(b) as amended by Section 2501(c) of the Affordable Care Act (ACA).

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
New estimate was determined based on current actual data from FY 2012-13.

Methodology:
1. Rebates are invoiced quarterly and payments occur four months after the conclusion of each quarter.

2. Assume the annual invoice amount for FY 2013-14 is $280,000,000.

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 34

3. For FY 2013-14, assume the overall collection rate will be 90% of invoiced amounts beginning in FY 2013-14, and $136,347,000 will be collected from the retroactive rebates (2010Q1 – 2013Q1)

FY 2013-14		
$280,000,000 x 90%	=	$252,000,000
$252,000,000 + $136,347,000	=	**$388,347,000**

4. For FY 2014-15, assume the there is a 5% increase to the annual collection rate due to the expansion of managed care into rural areas, and overall collection rate will continue to be 90% of invoiced amounts beginning in FY 2014-15, and $27,829,000 will be collected from the retroactive rebates (2010Q1 – 2013Q1)

FY 2014-15		
($280,000,000 x 105%) x 90%	=	$264,600,000
$264,600,000 + $27,829,000	=	**$292,429,000**

5. Estimated collections for FY 2013-14 and FY 2014-15:

(Dollars in Thousands)

Managed Care Drug Rebates FY 2013-14	
Retroactive Collections (2010Q1 – 2013Q1)	$ 136,347
To be Collected from FY 2013-2014	$ 252,000
Total FY 2013-14	**$ 388,347**
Managed Care Drug Rebates FY 2014-15	
Retroactive Collections (2010Q1 – 2013Q1)	$ 28,500
To be Collected from FY 2013-2014	$ 264,000
Total FY 2014-15	**$ 292,500**

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

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ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	5/2013
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1476

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$206,024,000	$256,044,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$206,024,000	$256,044,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$206,024,000	$256,044,000

DESCRIPTION

Purpose:
This policy change estimates the federal match to the California Department of Developmental Services (CDDS) for participant-directed Home and Community Based Services (HCBS) for persons with developmental disabilities under a 1915(i) state plan option.

Authority:
Section 6086 of the Deficit Reduction Act (DRA) of 2005, Public Law 109-171
Interagency Agreement 09-86388

Interdependent Policy Changes:
Not Applicable

Background:
The Department submitted a 1915(i) HCBS State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) in December 2009. The SPA proposes inclusion of certain services provided by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include: habilitation, respite care, personal care services, homemaker services, and home health aide services. The SPA was approved on April 25, 2013, with a retroactive effective date of October 1, 2009.

AB3 X 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. The SPA proposes to restore reimbursement for the eliminated services rendered in FY 2011-12 and forward, enabling persons with developmental disabilities access to these benefits.

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 35

In June 2012, an additional SPA was submitted to CMS to allow participants to self-direct selected HCBS under the 1915(i) program retroactive to April 1, 2012.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2009 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional Federal Financial Participation (FFP) for FY 2012-13 and FY 2013-14.

Reason for Change from Prior Estimate:
Pending federal approval has delayed implementation. Additionally, the SPA effective October 1, 2009 was split, further delaying the implementation and claiming for some services.

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

(Dollars in Thousands)

	Total Funds	CDDS GF	FFP	ARRA
FY 2013-14	$412,048	$206,024	**$206,024**	**$0**
FY 2014-15	$506,715	$250,671	**$253,358**	**$2,686**

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	7/2000
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	25

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$145,537,000	$145,124,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$145,537,000	$145,124,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$145,537,000	$145,124,000

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14132.06
AB 2608 (Chapter 755, Statutes of 2012), Welfare & Institutions Code, section 14115.8

Interdependent Policy Changes:
Not Applicable

Background:
LEAs, which consist of school districts, county offices of education, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA Medi-Cal Billing Option Program. Through the program, LEAs receive reimbursement for specific eligible health services provided to Medi-Cal eligible students to the extent federal financial participation (FFP) is available. LEAs receive interim payments based on interim reimbursement rates. A Cost and Reimbursement Comparison Schedule (CRCS) is submitted to the Department annually for the preceding fiscal year. Final payment reconciliation will be completed when the Department has audited the LEAs' cost report.

AB 2608 requires the Department to align state regulations such as Title 22, California Code of Regulations (CCR), Sections 51323, 51231.1, 51231.2, 51360, and 51491 related to school-based medical transportation services with federal regulations beginning January 1, 2013. This bill allows LEAs to receive Medi-Cal reimbursement for medical transportation services to students with disabilities.

Reason for Change from Prior Estimate:
The increase is due to recent legislation mandating reimbursement for medical transportation services to students.

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LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 36

Methodology:

1. Interim payments are based on the average total reimbursement amounts of the preceding three fiscal years.

2. The FY 2010-11 total transportation reimbursement represented approximately 4% of total LEA reimbursements, or $5,958,547 for that year. The estimated FY 2013-14 transportation reimbursement portion will assume 10% of the FY 2010-11 transportation reimbursement. $595,855 is incorporated in the FY 2013-14 interim payment total.

3. LEA Transportation reimbursement is estimated to increase due to the elimination of transportation restrictions, per AB 2608. For FY 2014-15, the Department estimates a 10% increase in transportation reimbursement based on the FY 2013-14 transportation reimbursement estimate. The total FY 2014-15 estimated amount for transportation is $655,440. This amount is incorporated in the FY 2014-15 interim payment portion.

4. The Department has completed the final reconciliation for FY 2007-08 and expects to make the final cost settlement of approximately $3,700,000 in FY 2013-14.

5. The estimated reconciliation for FY 2008-09 is $4,000,000.

6. The estimate is based on the analysis of historical claims submitted by LEAs.

(Dollars In Thousands)	TF	FF
FY 2013-14 Interim Payments	$141,837	$141,837
FY 2007-08 Reconciliation	$3,700	$3,700
FY 2013-14 Total	**$145,537**	**$145,537**
FY 2014-15 Interim Payments	$141,124	$141,124
FY 2008-09 Reconciliation	$4,000	$4,000
FY 2014-15 Total	**$145,124**	**$145,124**

Funding:

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	12/2008
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1228

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$51,410,000	$24,679,000
- STATE FUNDS	$1,474,000	$2,707,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$51,410,000	$24,679,000
STATE FUNDS	$1,474,000	$2,707,000
FEDERAL FUNDS	$49,936,000	$21,972,000

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 52 California Community Transitions Savings
PC 43 CCT Fund Transfer to CDSS and CDDS
PC 46 Quality of Life Surveys for CCT Participants

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

Participants are enrolled in the demonstration for a maximum of 12 months, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2013 through June 30, 2014 are 500 individuals and 504 individuals for July 1, 2014 through June 30, 2015.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD beneficiaries

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 37

expected to transition into CCT is included in this policy change. The cost of transitioning, providing HCBS, and the supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change from Prior Estimate:
Current year costs increased because payments for outstanding claims from prior fiscal years were not paid in the previous fiscal year as expected, as well as a decline in estimated CCT participants.

Methodology:

1. Assume estimated costs for persons residing year-round in Nursing Facility (NF)-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be $66,558. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of $8,566 annually; reimbursed at 75% MFP and 25% GF.

3. Assume pre-transitions that are unsuccessful for non-DD beneficiaries cost $1,838 annually in FY 2013-14 and $1,930 annually in FY 2014-15; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $44,713 annually in FY 2013-14 and $46,949 annually in FY 2014-15; reimbursed at 75% MFP and 25% GF.

5. Assume DD beneficiaries who participate in CCT have a one-time cost of $64,587 for pre-transition demonstration services; reimbursed at 75% MFP and 25% GF.

6. Assume DD beneficiaries, upon transitioning into CCT, cost $70,757 in FY 2013-14 and $74,295 in FY 2014-15 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.

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

8. Assume CDDS will request FFP for CCT services provided to DD beneficiaries for FY 2010-11 and FY 2011-12 in FY 2013-14.

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

(Dollars in Thousands)

	FY 2013-14		FY 2014-15	
	TF	**GF**	**TF**	**GF**
Lagged savings	($13,558)	($6,779)	($18,163)	($9,082)
Lagged costs	**$22,446**	**$1,474**	**$24,679**	**$2,707**
CDDS prior year costs	**$28,964**	**$0**	**$0**	**$0**
Net	$37,852	($5,305)	$6,516	($6,375)

Funding:
100% GF (4260-101-0001)
MFP Federal Grant (4260-106-0890)

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RESTORATION OF SELECT ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	5/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1798

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$10,888,000	$239,531,000
- STATE FUNDS	$3,315,500	$72,941,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,888,000	$239,531,000
STATE FUNDS	$3,315,500	$72,941,000
FEDERAL FUNDS	$7,572,500	$166,590,000

DESCRIPTION

Purpose:
This policy change estimates the benefit costs to restore partial adult optional dental benefits.

Authority:
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:
OA 24 Restoration of Select Adult Dental Benefits

Background:
ABX3 5 (Chapter 20, Statutes of 2009) discontinued Medi-Cal optional services for adults 21 years of age or older who are not in nursing facilities and excluding pregnant women. ABX3 5 eliminated the full scope of adult optional dental benefits, including full denture related procedures and “restore but not replace” procedures. Currently, Medi-Cal only covers the services that are Federally Required Adult Dental Services (FRADS).

AB 82 restores partial adult optional dental benefits, including full mouth dentures.

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% of the federal poverty level (FPL). The ACA expansion includes:

- ACA Mandatory Expansion: cover the currently Medi-Cal eligible but not enrolled beneficiaries.
- ACA Optional Expansion: expand coverage to newly eligibles.

The optional dental benefit cost for the expanded population due to the ACA is included in this policy change.

Reason for Change from Prior Estimate:
The estimated number of eligibiles for optional ACA for May 2014 to June 2014 decreased. The estimate for FY 2014-15 is for a complete year.

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RESTORATION OF SELECT ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 38

Methodology:

1. Assume the implementation date is May 2014.

2. In FY 2013-14, the average per-member-per-month (PMPM) for adult optional dental benefits is $11.07 and $0.92 for the administrative costs. Assume the annual utilization growth rate is 2.85% and no growth for the PMPM.

3. In FY 2013-14, the total current population is 2,104,086 member months, and it is estimated 488,411 member months will enroll in Medi-Cal under the ACA mandatory expansion and 1,367,488 member months under the ACA optional expansion. Assume 24% of ACA mandatory expansion eligibles are children.

4. In FY 2014-15, the total current population is 12,624,516 member months, and it is estimated 3,743,276 member months will enroll in Medi-Cal under the ACA mandatory expansion and 9,228,832 member months under the ACA optional expansion. Assume 24% of ACA mandatory expansion eligibles are children.

5. Assume a six month phase-in.

6. The total estimated costs for adult optional dental benefits are:

FY 2013-14
(Dollar in Thousands)

	TF	FFP	GF
Benefit Costs			
Current Medi-Cal (50/50)	$4,492	$2,246	$2,246
ACA Mandatory Expansion (50/50)	$2,139	$1,069	$1,069
ACA Optional Expansion (100% FFP)	$4,257	$4,257	$0
Total Benefit Costs	**$10,888**	**$7,572**	**$3,315**

FY 2014-15
(Dollar in Thousands)

	TF	FFP	GF
Benefit Costs			
Current Medi-Cal (50/50)	$98,819	$49,410	$49,409
ACA Mandatory Expansion (50/50)	$47,064	$23,532	$23,532
ACA Optional Expansion (100% FFP)	$93,649	$93,649	$0
Total Benefit Costs	**$239,532**	**$166,591**	**$72,941**

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	7/1984
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	28

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$40,464,000	$40,464,000
- STATE FUNDS	$20,232,000	$20,232,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,464,000	$40,464,000
STATE FUNDS	$20,232,000	$20,232,000
FEDERAL FUNDS	$20,232,000	$20,232,000

DESCRIPTION

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

Authority:
Welfare & Institutions Code 9560-9568
Welfare & Institutions Code 14132.275
Welfare & Institutions Code 14186
SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are determined to be "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services (HCBS) waiver for up to 13,080 participants in 9,440 client slots, at $4,285 per year per client slot.

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only. Beginning April 1, 2014, the Department will mandatorily enroll dual eligibles and SPDs into managed care for their Medi-Cal benefits. Those benefits comprise long-term supports and services (LTSS) including facility-based long-term care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and MSSP. Under CCI, managed care capitation will include MSSP services. In the eight CCI demonstration counties, participating managed care health plans will contract with the MSSP sites in their service area to deliver MSSP waiver services to their eligible health plan members. Eligible plan member will be enrolled into the MSSP waiver, subject to the availability of a waiver slot.

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MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 39

Beginning April 1, 2014, MSSP will transition to being a Medi-Cal managed care benefit in three CCI demonstration counties (Alameda, San Mateo, and Santa Clara). On July 1, 2014, this transition will become effective in the remaining five CCI demonstration counties (Los Angeles, Orange, San Diego, San Bernardino, and Riverside). The total MSSP reimbursement (both for fee-for-service (FFS) and managed care (MC)) is budgeted in this policy change.

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

Methodology:

(Dollars in Thousands)

	TF	Reimbursement from CDA	FFP
FY 2013-14	**$40,464**	$20,232	$20,232
FY 2014-15	**$40,464**	$20,232	$20,232

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

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	4/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1775

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$39,990,000	$34,170,000
- STATE FUNDS	$19,995,000	$17,085,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$39,990,000	$34,170,000
STATE FUNDS	$19,995,000	$17,085,000
FEDERAL FUNDS	$19,995,000	$17,085,000

DESCRIPTION

Purpose:
This policy change estimates the costs of implementing organized health care delivery systems for the California Children's Services (CCS) Medi-Cal beneficiaries.

Authority:
ABX4 6 (Chapter 6, Statutes of 2009)
SB 208 (Chapter 714, Statutes of 2010)
California Bridge to Reform, Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
OA 2 CCS Case Management
PC 115 County Organized Health Systems (COHS)
PC 159 Extend Hospital QAF – Hospital Payments
PC 121 Extend Gross Premium Tax – Incr. Capitation Rates
PC 137 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 BTR, approved by the Centers for Medicare and Medicaid Services effective November 1, 2010, allows the Department to develop and implement up to four organized health care delivery models to serve the CCS Medi-Cal eligible population. Four health care delivery models considered for the Demonstration are:

- Enhanced primary care case management model,
- Provider-based accountable care organization model,
- Existing Medi-Cal managed care plans, and
- Specialty health care plan.

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 40

Five entities responded and were granted approval to develop demonstrations under the Department's 1115 Bridge to Reform Waiver. These entities include:

- Health Plan of San Mateo (HPSM) as an existing managed care organization,
- Alameda County as a Primary Care Case Management model,
- LACare as a specialty health care plan,
- Rady Children's Hospital as an Accountable Care Organization, and
- Children's Hospital Orange County as an Accountable Care Organization.

The HPSM began operations effective April 1, 2013.

Reason for Change from Prior Estimate:
The average monthly enrollment estimate increased to account for the potential increase in Medi-Cal eligibility due to the implementation of the Affordable Care Act.

Methodology:

1. The CCS Pilot program transitioned CCS Medi-Cal beneficiaries residing in San Mateo County from the COHS to the HPSM.

2. The estimated capitation rate for HPSM is $1,417.28, including health care and administrative costs.

Average Monthly Enrollment	Capitation Rate	Monthly Payment	Annual Payment
2,000	$1,417.28	$2,835,000	$34,020,000

3. Assume the annual administrative cost of $3,477,000, 70% of the CCS Medi-Cal administrative costs will be transferred to the HPSM.

   Annual HPSM administrative costs:
   $3,477,000 x 70% = $2,434,000 TF (monthly $203,000 TF)

4. The HPSM received the capitation payments beginning May 2013.

5. Assume the June capitation payment will be deferred to the following fiscal year.

6. Assume the CCS Pilot program is budget neutral.

(Dollars in Thousands)

	TF	HPSM	COHS	CCS Case Management
FY 2013-14	$0	**$39,690**	($36,848)	($2,842)
FY 2014-15	$0	**$34,020**	($31,586)	($2,434)

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 40

7. The estimated capitation payments on a cash basis are:

(Dollars in Thousands)

FY 2013-14	TF	FFP	GF
HPSM	$39,690	$19,845	$19,845
UCLA-IE	$300	$150	$150
Total	**$39,990**	**$19,995**	**$19,995**

FY 2014-15	TF	FFP	GF
HPSM	$34,020	$17,010	$17,010
UCLA-IE	$150	$75	$75
Total	**$34,170**	**$17,085**	**$17,085**

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

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	1/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1772

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,085,000	$6,345,000
- STATE FUNDS	$776,000	$34,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,085,000	$6,345,000
STATE FUNDS	$776,000	$34,000
FEDERAL FUNDS	$4,309,000	$6,311,000

DESCRIPTION

Purpose:
This policy change budgets the federal financial participation (FFP) for Youth Regional Treatment Centers (YRTCs).

Authority:
Public Law 102-573 (Title 25, U.S.C. 1665c)
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department will implement the enrollment and reimbursement of YRTCs for services rendered to American Indian youths. The Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance abuse treatment. The Department will receive 100% Federal Medical Assistance Percentage (FMAP) under Title XIX for YRTC services provided to eligible American Indian Medi-Cal members under the age of 21.

Reason for Change from Prior Estimate:
The change is due to a delay in implementation and rate adjustments.

Methodology:

1. Assume the program effective date is September 1, 2013. The Department expects to make payments beginning January 2014.

2. Details of the estimated expenditures:
   a. The estimated annual number of youths: 50
   b. The average stay per youth: 180 days
   c. The estimated daily rate per youth: Calendar Year 2013 rate is $660
   d. The estimated daily rate is estimated to increase annually by $30.

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 41

FY 2013-14
(2013 calendar year rate of $660)
50 youths x 180 days per youth x $660 per day = $5,940,000 TF annually, or $495,000 TF per month.

(2014 calendar year rate of $690)
50 youths x 180 days per youth x $690 per day = $6,210,000 TF annually, or $3,105,000 TF semi-annually.

FY 2014-15
(2014 calendar year rate of $690)
50 youths x 180 days per youth x $690 per day = $6,210,000 TF annually, or $3,105,000 TF semi-annually.

(2015 calendar year rate of $720)
50 youths x 180 days per youth x $720 per day = $6,480,000 TF annually, or $3,240,000 TF semi-annually.

3. Assume the program will pay the quarterly expenditures upfront at 50% FMAP, and receive Federal Financial Participation (FFP) reimbursement in the following quarter.

Amounts may differ due to rounding.

FY 2013-14	**TF**	**GF**	**FFP**
Sept. 2013-Dec. 2013	$1,980,000	$990,000	$990,000
*Sept. 2013-Dec. 2013	$0	($990,000)	$990,000
Jan. 2014-June 2014	$3,105,000	$776,000	$2,329,000
Total FY 2013-14	**$5,085,000**	**$776,000**	**$4,309,000**
FY 2014-15			
*Apr.-June 2014	$0	($776,000)	$776,000
July 2014-Dec 2014	$3,105,000		$3,105,000
**Jan. 2015-June 2015	$3,240,000	$810,000	$2,430,000
Total FY 2014-15	**$6,345,000**	**$34,000**	**$6,311,000**

* FFP reimbursement from previous quarter
** FFP to be reimbursed in FY 2015-16

Funding:
50% GF / 50% Title XIX FFP (4260-101-001/0890)
100% Title XIX FFP (4260-101-0890)

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DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING

REGULAR POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	4/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1754

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,631,000	$4,841,000
- STATE FUNDS	$2,315,500	$2,420,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,631,000	$4,841,000
STATE FUNDS	$2,315,500	$2,420,500
FEDERAL FUNDS	$2,315,500	$2,420,500

DESCRIPTION

Purpose:
This policy change estimates the costs due to increased utilization for breast cancer screening services as a result of notification of dense breast.

Authority:
SB 1538 (Chapter 458, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1538 requires health facilities, administering mammograms to women 40 years of age and over, to notify patients whose breasts are categorized as being heterogeneously or extremely dense. The notification informs patients that they may benefit from supplementary screening due to the level of dense breast tissue (DBT) seen on the mammogram. The generated notices will result in patients requesting additional screening tests, such as magnetic resonance imaging (MRIs) and ultrasounds. The provisions of this bill became operative April 1, 2013 and will sunset on January 1, 2019.

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

Methodology:
1. Implementation began on April 1, 2013.

2. Assume mammography exams include screening and diagnostic.

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DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING

REGULAR POLICY CHANGE NUMBER: 42

3. Based on FY 2010-11 data, the average number of women who received a mammography exam is 585,739 per year for age 40 and over for fee for service.

   40 – 49 years: 211,809
   50 and over: 373,930
   Total 585,739

4. According to data presented by the American Society of Breast Surgeons (ASBS) in 2009, 75% of women 40 – 49 years of age and 42% of women over 50 years of age have dense breasts.

   40 – 49 years: 211,809 x 75% = 158,857
   50 and over: 373,930 x 42% = 157,051
   Total 315,908

5. Assume 30% of women, who receive a notice, would request a supplementary screening test from their physician, such as an ultrasound.

   315,908 x 30% = 94,772

6. Assume the reimbursement rate per ultrasound is $49.35.

   94,772 x $49.35 = $4,677,000

7. Assume a lag of 0.955 for FY 2013-14 for fee for service.

8. For managed care, assume expenditures to be $164,000 annually.

FY 2013-14	**TF**	**GF**	**FFP**
FFS (lagged)	$4,467,000	$2,233,500	$2,233,500
Managed Care	$164,000	$82,000	$82,000
Total FY 2013-14	**$4,631,000**	$2,315,500	$2,315,500

FY 2014-15	**TF**	**GF**	**FFP**
FFS	$4,677,000	$2,338,500	$2,338,500
Managed Care	$164,000	$82,000	$82,000
Total FY 2014-15	**$4,841,000**	$2,420,500	$2,420,500

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

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CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	10/2011
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1562

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,678,000	$3,415,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,678,000	$3,415,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,678,000	$3,415,000

DESCRIPTION

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

Authority:
Federal Deficit Reduction Act of 2005 6071
Affordable Care Act (ACA)
Interagency Agreement 09-86345 (CDDS)
Interagency Agreement 10-87274 (CDSS)

Interdependent Policy Changes:
Not Applicable

Background:
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through September 30, 2016. The grant requires the Department to develop and implement strategies to assist 4,428 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition into federally-qualified residences with the support of Medi-Cal Home and Community-Based Services (HCBS).

Reason for Change from Prior Estimate:
Due to a decrease in actual and projected CCT participation, costs declined.

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

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 43

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

3. In FY 2010-11, the Department established an interagency agreement (IA) with CDDS and in FY 2011-12 an IA was established with CDSS. These IAs transfer the additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.

4. Assume 64% of all non-DDS enrollees utilize IHSS under CCT. Assume each case costs $27,631 in FY 2013-14 and $29,012 in FY 2014-15. The Department will provide 25% of these costs to CDSS.

5. Assume CDDS will receive 25% of the post transitional services costs for the DD population.

Estimated Costs:

	FY 2013-14	FY 2014-15
CDSS	$1,317,000	$1,402,000
CDDS	$1,361,000	$2,013,000
Total	**$2,678,000**	**$3,415,000**

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

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PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	7/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1787

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$540,000	$540,000
- STATE FUNDS	$270,000	$270,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$540,000	$540,000
STATE FUNDS	$270,000	$270,000
FEDERAL FUNDS	$270,000	$270,000

DESCRIPTION

Purpose:
This policy change estimates the payments to participating Pediatric Palliative Care Waiver (PPCW) agencies for administrative costs.

Authority:
AB 1745 (Chapter 340, Statutes of 2006)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1745 required the Department to submit an application to the Centers for Medicare and Medicaid Services (CMS) for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The waiver was approved beginning April 1, 2009 through March 31, 2012. A waiver renewal was approved by CMS through March 31, 2017.

Currently, the Department does not reimburse PPCW agencies for administrative costs. This policy change provides $300 per member per month to reimburse the PPCW agencies for indirect services, such as administrative support, overhead, and program training.

Reason for Change:
There is no change.

Methodology:
The following assumptions were used to estimate the program cost adjustment:

1. Assume a total of 150 members enroll in PPCW annually.

2. Assume a $300 per member per month cost for administrative costs.

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 44

3. This program is effective July 1, 2013.

150 members x $300 per member per month x 12 months = $540,000

	GF	FF	TF
FY 2013-14	**$270,000**	**$270,000**	**$540,000**
FY 2014-15	**$270,000**	**$270,000**	**$540,000**

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	8/2012
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1436

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$183,000	$501,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$183,000	$501,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$183,000	$501,000

DESCRIPTION

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

Authority:
AB 2968 (Chapter 830, Statutes of 2006)
1915(c) Home and Community Based Services Waiver (CA.0855)

Interdependent Policy Changes:
Not Applicable

Background:
The Department is working with the San Francisco Department of Public Health, under the authority of a 1915(c) Home and Community Based Services (HCBS) Waiver to serve Medi-Cal beneficiaries who are:

- 21 years of age and older,
- reside in the City or County of San Francisco,
- and who would otherwise live in nursing facilities or be rendered homeless.

CMS approved the waiver for a five year period beginning July 1, 2012 through June 30, 2017.

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

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

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SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 45

Reason for Change from Prior Estimate:
The estimated costs decreased because actual enrollment did not meet what was previously projected.

Methodology:

1. The waiver has a maximum capacity of 486 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment began in August 2012. Target enrollment for the period of July 1, 2013 through June 30, 2014 has been reduced to 29 individuals and 53 individuals for July 1, 2014 through June 30, 2015.

2. The enrollment will be phased in throughout the year. Total participant months in FY 2013-14 will be 218, and 304 in FY 2014-15.

3. Due to a four-month payment lag, 36 participant months from FY 2012-13, along with 114 participant months from FY 2013-14 will be paid in FY 2013-14. The remaining 104 participant months will be paid in FY 2014-15, along with 504 participant months for FY 2014-15.

4. The annual total cost is estimated to be $29,475 per participant in FY 2013-14 and FY 2014-15.

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

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

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

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	7/2010
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1550

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$131,000	$141,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$131,000	$141,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$131,000	$141,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the Quality of Life (QoL) surveys administered to all California Community Transitions (CCT) project participants.

Authority:
Affordable Care Act (P.L. 111-148), Section 2403
Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
Money Follows the Person (MFP) Rebalancing Demonstration (P.L. 109-171)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) requires the Department to conduct QoL surveys with CCT participants in receipt of MFP grant funds. QoL surveys are given within specified timeframes and follow a specific methodology. CCT provider agencies, which are Medi-Cal Home and Community Based Services (HCBS) enrolled providers, conduct QoL surveys designed for the following situations:

1. Baseline QoL-Conducted within 30-days before transition or within 10 days after the initial transition.
2. First Follow-up QoL-Conducted 11-12 months after the initial transition.
3. Second Follow-up QoL-Conducted 24 months after initial transition.

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

Reason for Change from Prior Estimate:
Costs have decreased due to a decline in actual and projected CCT participants.

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 46

Methodology:

1. The QoL surveys began in July 2010.

2. In FY 2011-12, 403 beneficiaries were transitioned in the CCT demonstration project and 404 additional beneficiaries transitioned into CCT in FY 2012-13. Projected enrollments are 500 in FY 2013-14 and 504 in FY 2014-15.

3. Assume the QoL surveys are administered to all CCT participants three times over a span of three years. Assume first follow-up QoLs are conducted 11 months after the initial transition. The second follow-up survey is conducted approximately two years after they have been living in community settings.

4. Assume the Department reimburses $100 to Medi-Cal providers per completed survey for survey administration.

500 x $100 = $50,000 Baseline
404 x $100 = $40,400 First follow up
403 x $100 = $40,300 Second follow up

FY 2013-14 Estimated Costs: **$131,000 TF**

504 x $100 = $50,400 Baseline
500 x $100 = $50,000 First follow up
404 x $100 = $40,400 Second follow up

FY 2014-15 Estimated Costs: **$141,000 TF** (rounded)

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

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INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	7/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1557

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$3,794,100	-$3,794,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	66.48 %	81.71 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,271,780	-$693,940
FEDERAL FUNDS	$1,271,780	$693,940

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:
Not Applicable

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

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

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

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

INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 47

3. Based on FY 2009-10 data, costs for eligible family planning services and supplies were $3,969,000 GF, and costs for family planning-related services were $444,000 GF, for a total cost of $4,413,000 GF.

(Dollars in Thousands) Total Cost		**New FFP**
$3,969 x 90%	=	$3,572
$444 x 50%	=	$222
$4,413		$3,794

4. With enhanced funding, costs for these services and supplies will be $3,794,000 FFP and $619,000 GF for a GF savings of $3,794,000 annually.

(Dollars in Thousands)	**GF**	**FF**
FY 2013-14 Savings	**($3,794)**	$3,794
FY 2014-15 Savings	**($3,794)**	$3,794

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

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HEARING AID CAP

REGULAR POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1515

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,434,000	-$1,434,000
- STATE FUNDS	-$717,000	-$717,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

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

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

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

Methodology:
1. Savings began on July 1, 2012.

2. Actual annual hearing aid expenditures for FY 2010-11 were $22,329,000 for 25,868 unduplicated users.

3. Of the annual hearing aid expenditures amount, $1,751,000 were associated with beneficiaries residing in long-term care and pregnant women, and $2,132,000 were associated with beneficiaries under 21 years of age.

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 48

$1,751,000 + $2,132,000 = $3,883,000

4. Expenditures subject to cap are: $22,329,000 - $3,883,000 = $18,446,000

5. Based on paid claims for hearing aids for dates of service between July 1, 2010 and June 30, 2011, total FFS hearing aids expenditures below the $1,510 cap were $9,956,000 for 14,720 beneficiaries.

6. Based on paid claims for hearing aids for dates of service between July 1, 2010 and June 30, 2011, an average of $1,582 is spent annually per beneficiary at and above the $1,510 expenditure cap.

7. There are 5,365 adult users above the $1,510 Cap. The allowable costs for these users is $8,101,000.

(Dollars in Thousands)	Users	Expenditures
Total unduplicated users	25,868	$22,329
LTC, children, & pregnant women	5,783	$3,883
Expenditures subject to cap	20,085	$18,446
Below the $1,510 cap for adults	14,720	$9,956
Above the $1,510 cap for adults	5,365	$8,490

(Dollars in Thousands)	TF	GF	FFP
Annual FFS Expenditures	($22,329)	($11,164)	($11,165)
LTC, children, & pregnant women	$3,883	$1,941	$1,942
Expenditures Subject to Cap	($18,446)	($9,223)	($9,223)
FFS Expenditures < $1,510 cap	$9,956	$4,978	$4,978
FFS Expenditures > $1,510 cap	($8,490)	($4,245)	($4,245)
Allowable costs for > the $1,510 cap	$8,101	$4,050	$4,051
Annual FFS savings due to cap	($389)	($194)	($195)
Annual Managed Care savings due to cap	($1,045)	($522)	($523)
Total Annual Savings	($1,434)	($717)	($717)
FY 2013-14			
FFS	($389)	($194)	($195)
Managed Care	($1,045)	($522)	($523)
Total FY 2013-14	**($1,434)**	**($717)**	**($717)**
FY 2014-15			
FFS	($389)	($194)	($194)
Managed Care	($1,045)	($522)	($522)
Total FY 2014-15	**($1,434)**	**($717)**	**($717)**

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

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SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1007

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$92,051,700	-$92,051,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$92,051,700	-$92,051,700
FEDERAL FUNDS	$92,051,700	$92,051,700

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $135,325,000 in FY 2013-14 and $135,325,000 in FY 2014-15.

2. Based on the estimated costs and 65% SCHIP FFP, the following amounts are budgeted for FY 2013-14 and FY 2014-15:

FY 2013-14:	$135,325,000 x .65 =	$87,961,000 FFP
FY 2014-15:	$135,325,000 x .65 =	$87,961,000 FFP

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 49

3. The estimated prenatal care cost for legal immigrants, who have been in the country for less than five years, is $6,293,000 for FY 2013-14 and $6,293,000 for FY 2014-15.

FY 2013-14:	$6,293,000 x .65 SCHIP FFP =	$4,090,000 FFP
FY 2014-15:	$6,293,000 x .65 SCHIP FFP =	$4,090,000 FFP

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

FY 2013-14 Savings:	$87,961,000 + $4,090,000 =	**$92,051,000**
FY 2014-15 Savings:	$87,961,000 + $4,090,000 =	**$92,051,000**

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

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COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	7/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1524

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$33,707,000
- STATE FUNDS	$0	-$16,853,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$33,707,000
STATE FUNDS	$0	-$16,853,500
FEDERAL FUNDS	$0	-$16,853,500

DESCRIPTION

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

Authority:
AB 97 (Chapter 3, Statutes of 2011), Welfare & Institutions Code 14134(c)(1)
AB 1467 (Chapter 23, Statutes of 2012)

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:
AB 97 implemented a mandatory copayment of up to $50 for non-emergency use of the emergency room. After discussion with the Centers for Medicare & Medicaid Services (CMS), the Department will implement a $15 copayment for non-emergency medical care provided in an emergency room.

The Department will submit an amendment to the 1115 Demonstration Project Waiver to CMS for approval to implement a two-year demonstration project in managed care settings. The copayment proposal will not apply to children in Aid to Families with Dependent Children (AFDC)-Foster Care, American Indian/Alaskan Natives, and beneficiaries who are dual eligible for both Medicare and Medi-Cal. The provider will collect the $15 copayment from the beneficiaries after receipt of non-emergency medical care in the emergency room.

Reason for Change from Prior Estimate:
Implementation date changed from July 1, 2013 to July 1, 2014 because of delay in expected federal approval.

Methodology:
1. It is assumed that the copayment will be implemented July 1, 2014.

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 50

2. The managed care savings are estimated to be **$33,707,000 TF ($16,853,500 GF)** annually.

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

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WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	11/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1770

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$12,011,000	-$10,351,000
- STATE FUNDS	-$4,924,400	-$2,374,900
PAYMENT LAG	0.6902	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,290,000	-$10,351,000
STATE FUNDS	-$3,398,820	-$2,374,900
FEDERAL FUNDS	-$4,891,170	-$7,976,100

DESCRIPTION

Purpose:
This policy change estimates the cost and cost-avoidance from reproductive health services benefit changes to the Family Planning, Access, Care and Treatment (Family PACT) and Medi-Cal programs.

Authority:
Welfare & Institutions Code 14132(aa)(8)
Affordable Care Act, Section 2303(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
The Department conducts on-going monitoring and utilization management of reproductive health services to expand access to services, evaluate the cost-effectiveness of services, and identify opportunities to reduce program costs while maintaining the same quality of care.

Expanding access to long-acting reversible contraceptives (LARCs) gives women greater choice in selecting a contraceptive that meets their needs for delaying, spacing, or limiting pregnancy. LARCs have the highest continuation rates of all the family planning methods, and conversely, the lowest discontinuation rates, and as such, are more effective in actual use than short-acting methods for preventing unintended or closely spaced pregnancy. The cost-benefit associated with use of LARCs is greater than all other contraceptive methods.

Until greater utilization of the most effective birth control methods (LARCs) occurs, for those women that have disparate access to family planning services, prescriptions for less effective methods of birth control, are victims of birth control sabotage, or other circumstances beyond their control, an increase in reimbursement rates for pregnancy termination services is warranted. These sensitive services must be immediately accessible statewide and provided in a very timely manner. Early statewide access insures services are less costly, whereas lack of access results in increased ongoing expenses for years. An increase in reimbursement rates will provide early and consistent access to services and significant cost-avoidance.

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 51

For Family PACT, effective November 1, 2013, the Department plans to:

- Eliminate urine culture, and
- Discontinue brand name anti-fungal drugs.

For Family PACT and Medi-Cal Fee-for-Service, effective November 1, 2013, the Department plans to:

- Add onsite dispensing of the emergency contraceptive, ella®,
- Decrease the onsite dispensing of emergency contraception under Family PACT from two (2) packs per dispensing to one (1) pack per dispensing,
- Increase the dispensing fee for LARCs, and
- Increase reimbursement rates for pregnancy termination services under Medi-Cal by 40 percent.

For Family PACT, effective January 1, 2014, the Department plans to:

- Reduce chlamydia screening of women over 25 years of age, adopt a Medi-Cal Preferred List for oral contraceptives,
- Eliminate mammograms, and
- Eliminate pregnancy test-only benefit.

Reason for Change from Prior Estimate:
This is a new policy change.

Methodology:
1. The estimated savings below is based on FY 2011-12 data:

Benefit	FMAP*	FY 2013-14 TF	FY 2014-15 TF
Chlamydia Screening	90%	($8,293,000)	($16,586,000)
Emergency Contraception	90%	($3,670,000)	($5,505,000)
Clinical dispensing of ella®	90%	$5,400,000	$8,054,000
Medi-Cal List of Oral Contraceptives	90%	($2,000,000)	($4,000,000)
Mammograms	0%	($2,521,000)	($5,042,000)
Urine Culture	50%	($223,000)	($335,000)
Brand Name Antifungal Drug	50%	($541,000)	($812,000)
Pregnancy Test Only	90%	($163,000)	($325,000)
LARC Fee Increase	90%	$0	$8,700,000
Abortion Rate Increase	0%	$0	$5,500,000
Total Savings		**($12,011,000)**	**($10,351,000)**

*FMAP: Federal Medical Assistance Percentage

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

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WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 51

FY 2013-14	TF	GF	FFP
90/10 Savings	($7,509,000)	($751,000)	($6,758,000)
50/50 Savings	($658,000)	($329,000)	($329,000)
100% GF Savings	($3,845,000)	($3,845,000)	$0

FY 2014-15	TF	GF	FFP
90/10 Savings	($8,314,000)	($831,000)	($7,483,000)
50/50 Savings	($987,000)	($493,500)	($493,500)
100% GF Savings	($1,050,000)	($1,050,000)	$0

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

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CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	12/2008
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1222

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$13,558,000	-$18,163,000
- STATE FUNDS	-$6,779,000	-$9,081,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$13,558,000	-$18,163,000
STATE FUNDS	-$6,779,000	-$9,081,500
FEDERAL FUNDS	-$6,779,000	-$9,081,500

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 37 California Community Transitions Costs

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

Participants are enrolled in the demonstration for a maximum of 12 months, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2013 through June 30, 2014 are 500 individuals and 504 individuals for July 1, 2014 through June 30, 2015.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD beneficiaries expected to transition into CCT is included in this policy change. The cost of transitioning, providing

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 52

HCBS, and the supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change from Prior Estimate:
The participant phase-in has been revised, resulting in fewer eligible months and lower savings.

Methodology:

1. Assume estimated costs for persons residing year-round in Nursing Facility (NF)-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be $66,558. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of $8,566 annually; reimbursed at 75% MFP and 25% GF.

3. Assume pre-transitions that are unsuccessful for non-DD beneficiaries cost $1,838 annually in FY 2013-14 and $1,930 annually in FY 2014-15; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $44,713 annually in FY 2013-14 and $46,949 annually in FY 2014-15; reimbursed at 75% MFP and 25% GF.

5. Assume DD beneficiaries who participate in CCT have a one-time cost of $64,587 for pre-transition demonstration services; reimbursed at 75% MFP and 25% GF.

6. Assume DD beneficiaries, upon transitioning into CCT, cost $70,757 in FY 2013-14 and $74,295 in FY 2014-15 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.

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

8. Assume CDDS will request FFP for CCT services provided to DD beneficiaries for FY 2010-11 and FY 2011-12 in FY 2013-14.

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

(Dollars in Thousands)

	2013-14		2014-15	
	TF	**GF**	**TF**	**GF**
Lagged savings	**($13,558)**	**($6,779)**	**($18,163)**	**($9,082)**
Lagged costs	$22,446	$1,474	$24,679	$2,706
CDDS prior year costs	$28,964	$0	$0	$0
Net	$37,852	($5,305)	$6,516	($6,375)

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

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RESTORATION OF ENTERAL NUTRITION BENEFIT

REGULAR POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	5/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1801

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,356,000	$28,892,000
- STATE FUNDS	$1,678,000	$14,446,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,356,000	$28,892,000
STATE FUNDS	$1,678,000	$14,446,000
FEDERAL FUNDS	$1,678,000	$14,446,000

DESCRIPTION

Purpose:
This policy change estimates the cost of expanding Medi-Cal coverage of enteral nutrition.

Authority:
Welfare & Institutions Code 14132.86

Interdependent Policy Change:
Not Applicable

Background:
Enteral nutrition is nourishment that bypasses the upper digestive tract. AB 97 (Chapter 3, Statutes of 2011) limited enteral nutrition products to those products to be administered through a feeding tube. However, AB 97 exempts the beneficiaries under Early Periodic Screening, Diagnosis and Treatment (EPSDT) from the limit and allows the Department to deem an enteral nutrition product not administered through a feeding tube a benefit for patients with diagnoses including, but not limited to, malabsorption syndromes and inborn errors of metabolism.

AB 82 repeals the restrictions on enteral nutrition products, with specific medical and product criteria for oral and tube-feeding use, effective May 1, 2014.

Reason for Change from Prior Estimate:
There is no change

Methodology:
1. The restoration of enteral nutrition products will be implemented May 1, 2014.

2. Fee-for-service expenditures for enteral nutrition products for adults were approximately $32,777,000 annually before the AB 97 change.

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

RESTORATION OF ENTERAL NUTRITION BENEFIT

REGULAR POLICY CHANGE NUMBER: 53

4. The annual expenditures for the restoration of coverage are estimated to be:

   $32,777,000
   -$ 3,885,000
   $28,892,000 ($14,446,000 GF)

5. The restoration of coverage is assumed to begin May 1, 2014, so there are two months of CY impact:

   $28,892,000 x (2/12 months) = $4,815,333

6. There is a payment lag of 0.6970

   $4,815,333 x 0.6970 = $3,356,000

7. Total Expenditures:

(Dollars in Thousands)	TF	GF	FF
Total FY 2013-14	**$ 3,356**	**$ 1,678**	**$ 1,678**
Total FY 2014-15	**$ 28,892**	**$ 14,446**	**$14,446**

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

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NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	3/2007
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	108

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,920,000	$2,077,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,920,000	$2,077,000
FEDERAL FUNDS	-$1,920,000	-$2,077,000

DESCRIPTION

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

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

Interdependent Policy Changes
Not Applicable

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

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

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from January 2013 to March 2013.

Methodology:
1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased. Based on data from July 2004 to March 2013, the FFP actual total costs were compared to the base estimate amounts which created a percentage used to calculate the estimate.

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NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 54

(Dollars in Thousands)

	Non-FFP Drug Expenditures	Est. FFP Repayment
FY 2013-14	$3,840	**$1,920**
FY 2014-15	$4,154	**$2,077**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
Title XIX 100% GF (4260-101-0001)

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BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	1/2010
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1433

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$15,389,000	-$15,764,000
- STATE FUNDS	-$5,386,150	-$5,517,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$15,389,000	-$15,764,000
STATE FUNDS	-$5,386,150	-$5,517,400
FEDERAL FUNDS	-$10,002,850	-$10,246,600

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14105.33(b)(4)

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Projections were revised based on a decrease in new actual data from July 2012 to June 2013. The amount of money received from April 2013 to June 2013 decreased from previous quarters which caused the estimate to decrease.

Methodology:
1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. It is estimated that $15,389,000 in rebates will be collected for FY 2013–14 and $15,764,000 in rebates will be collected for FY 2014-15.

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BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 55

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

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MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	10/2006
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1181

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$18,321,000	-$18,321,000
- STATE FUNDS	-$9,160,500	-$9,160,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$18,321,000	-$18,321,000
STATE FUNDS	-$9,160,500	-$9,160,500
FEDERAL FUNDS	-$9,160,500	-$9,160,500

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The Department negotiates Maximum Acquisition Cost (MAC) for diabetic testing supplies with manufacturers to make available the best price to all providers. The Department establishes the product reimbursement rates for diabetic testing products which are based on the contracted MAC. The Department also negotiates rebates with some diabetic testing supply manufacturers to provide savings to the Department.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers for the contracted rebate percentage of the MAC.

Reason for Change from Prior Estimate:
There is a decrease based on the renegotiation of the new contract which will cause the quantity of claims to decrease by 25%.

Methodology:
1. The current medical supply diabetic testing products contract were renegotiated and the new contract is effective January 1, 2013.

2. Based on actual rebate data for the last four quarters, the average quarterly collection is $6,107,000.

3. Based on the renegotiation of the new contract, assume total claim units of services quantity will

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 56

decrease by 25%.

FY 2012-13:

($6,107,000 x 4 qtrs. = $ 24,428,000) x 75% (25% quantity decrease) = **$18,321,000**

FY 2013-14:

($6,107,000 x 4 qtrs. = $ 24,428,000) x 75% (25% quantity decrease) = **$18,321,000**

CASH BASIS	Medical Supply Rebates
FY 2011-12	$ 29,575,000
FY 2012-13	$ 24,234,000
Est. FY 2013-14	**$ 18,321,000**
Est. FY 2014-15	**$ 18,321,000**

Funding:

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

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FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	12/1999
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	51

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$72,232,000	-$74,815,000
- STATE FUNDS	-$9,248,400	-$9,579,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$72,232,000	-$74,815,000
STATE FUNDS	-$9,248,400	-$9,579,500
FEDERAL FUNDS	-$62,983,600	-$65,235,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14105.33 (b)(4)

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from February 2013 to July 2013.

Methodology:
1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.01% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 92.99% of the FPACT rebates.

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FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 57

2. We use actual data from January 2012 to July 2013 to project rebates.

CASH BASIS
(Dollars in Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2012-13	$148,213	($70,090)
Est. FY 2013-14	$152,985	**($72,232)**
Est. FY 2014-15	$161,687	**($74,815)**

	TF	50% FFP	90% FFP
FY 2013-14	**($72,232)**	($5,063)	($67,169)
FY 2014-15	**($74,815)**	($5,245)	($69,570)

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

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LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	8/2009
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1449

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$81,772,000	$0
- STATE FUNDS	-$81,772,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$81,772,000	$0
STATE FUNDS	-$81,772,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to overcharges.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Additional settlement agreements.

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LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 58

Methodology:
The following settlements are expected to be received in FY 2013-14:

	FY 2013-14
Amgen 2	($648,000)
Bioscrip	($65,000)
CareFusion	($784,000)
Dava Pharmaceuticals, Inc	($69,000)
ISTA Pharmaceuticals	($169,000)
Johnson & Johnson	($42,700,000)
Johnson & Johnson (Omnicare)	($1,848,000)
Kmart Corp.	($29,000)
KV Pharmaceuticals, Inc.	($59,000)
Medtronic	($17,000)
Pacific Health Corporation	($635,000)
Pfizer-Wyeth	($1,663,000)
Ranbaxy USA	($8,252,000)
Sanofi-Hyalgan	($36,000)
Seacliff Diagnostics	($124,000)
Senior Care Action Network	($24,673,000)
Victory Pharma	($1,000)
Total GF Savings	**($81,772,000)**

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

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AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	4/2004
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1182

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$150,000,000	-$150,000,000
- STATE FUNDS	-$74,611,200	-$74,611,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$150,000,000	-$150,000,000
STATE FUNDS	-$74,611,200	-$74,611,200
FEDERAL FUNDS	-$75,388,800	-$75,388,800

DESCRIPTION

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

Authority:
Welfare & Institutions Code, Section 14105.33

Interdependent Policy Changes:
PC 60 State Supplemental Drug Rebates
PC 61 Federal Drug Rebate Program

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

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

Reason for Change from Prior Estimate:
The Department's ability to recover an increased number of aged and disputed drug rebate payments has increased the estimated savings.

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AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59

Methodology:

1. Between July 1, 2012 and June 30, 2013 the Department collected $157,738,000 in aged and disputed rebates.

2. It is estimated that The Department will collect $150,000,000 in FY 2013-14 and $150,000,000 in FY 2014-15 in Aged and Disputed Rebates

(Dollars in Thousands)

	TF	GF	FFP
FY 2013-14 (50/50 FFP)	$ 149,028,000	$ 74,514,000	$ 74,514,000
FY 2013-14 (10/90 FFP)	$ 972,000	$ 97,200	$ 874,800
	$ 150,000,000	**$ 74,611,200**	**$ 75,388,800**

(Dollars in Thousands)

	TF	GF	FFP
FY 2014-15 (50/50 FFP)	$ 149,028,000	$ 74,514,000	$ 74,514,000
FY 2014-15 (10/90 FFP)	$ 972,000	$ 97,200	$ 874,800
	$ 150,000,000	**$ 74,611,200**	**$ 75,388,800**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

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STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	1/1991
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	54

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$165,789,000	-$180,941,000
- STATE FUNDS	-$82,464,900	-$90,001,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$165,789,000	-$180,941,000
STATE FUNDS	-$82,464,900	-$90,001,300
FEDERAL FUNDS	-$83,324,100	-$90,939,700

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14105.33

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from September 2012 to June 2013.

Methodology:
1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. In FY 2012-13, actual FFS drug expenditures were $2,384,818,900 of that amount, 6% were collected in State supplemental rebates.

3. In FY 2013-14 and FY 2014-15, it is assumed that 6% of projected FFS base drug expenditures will be collected as State supplemental rebates.

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STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 60

4. Family planning drugs account for 0.648% of rebates and are funded with 90% federal funds and 10% General Fund.

	FY 2013-14		FY 2014-15	
	TF	**GF**	**TF**	**GF**
Title XIX 50/50	($164,715,000)	($82,358,000)	($179,769,000)	($89,884,000)
Title XIX 10/90	($1,074,000)	($107,000)	($1,173,000)	($117,000)
Total	**($165,789,000)**	**($82,465,000)**	**($180,942,000)**	**($90,001,000)**

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

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FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	7/1990
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	55

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,335,187,000	-$1,457,217,000
- STATE FUNDS	-$608,132,700	-$668,831,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,335,187,000	-$1,457,217,000
STATE FUNDS	-$608,132,700	-$668,831,300
FEDERAL FUNDS	-$727,054,300	-$788,385,700

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from September 2012 to June 2013.

Methodology:
1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. In FY 2012-13, actual FFS drug expenditures were $2,384,818,900, of that amount, 50% were collected in Federal rebates.

3. FFS drug expenditures are declining because of the shift of Medi-Cal beneficiaries into managed care.

4. In FY 2013-14 and FY 2014-15, it is assumed that 50% of projected FFS base drug expenditures will be collected as rebates.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 61

5. Family planning drugs account for 0.648% of rebates and are funded with 90% federal funds and 10% General Fund.

6. Beginning July 2012, the ongoing additional federal financial participation (FFP) of $112,000,000, claimed by the Centers for Medicare and Medicaid Services (CMS), is fully reflected in this policy change.

	FY 2013-14		FY 2014-15	
	TF	**GF**	**TF**	**GF**
Title XIX 50/50	($1,214,535,000)	($607,268,000)	($1,335,775,000)	($667,887,000)
Title XIX 10/90	($8,652,000)	($865,000)	($9,443,000)	($944,000)
Title XIX	($112,000,000)	($0)	($112,000,000)	($0)
Total	**($1,335,187,000)**	**($608,133,000)**	**($1,457,218,000)**	**($668,831,000)**

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

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VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	1/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1811

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$9,468,000	$23,663,000
- STATE FUNDS	$4,030,000	$9,940,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,468,000	$23,663,000
STATE FUNDS	$4,030,000	$9,940,000
FEDERAL FUNDS	$5,438,000	$13,723,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement funds for the Voluntary Inpatient Detoxification service provided through the Drug Medi-Cal (DMC) program.

Authority:
SBX1 1 (Chapter 4, Statutes of 2013), Chapter 4, Section 29

Interdependent Policy Changes:
Not Applicable

Background:
Voluntary Inpatient Hospital Detoxification is an extension of Inpatient Hospital Services already described in the State Plan. This service is provided when determined medically necessary, and with the voluntary participation of the Medi-Cal beneficiary. This service is provided to a beneficiary who has been admitted to the hospital for general acute care inpatient services, and the beneficiary's stay must be continued beyond the beneficiary's need for general acute care inpatient services to address the detoxification medical necessity.

SBX1 1 requires Medi-Cal to cover substance use disorder services that are included in the essential health benefits package that the State adopted pursuant to Health & Safety Code, section 1367.005. Because that package includes additional services that are not currently covered under DMC, Medi-Cal will extend coverage for these new services, effective January 1, 2014. These changes affect the current Medi-Cal eligibles as well as the additional eligibles that are added as a result of the Affordable Care Act (ACA) mandatory and optional expansions.

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. For these new services, General Funds (GF) will be used to match federal funds.

Reason for Change from Prior Estimate:
This is a new policy change.

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 66

Methodology:

1. The DMC eligible caseload projections are based on the average monthly eligibles projected for the current, mandatory, and optional population expected to utilize Voluntary Inpatient Detoxification services.

2. Assume the caseload projection for the regular population is 1,343 for FY 2013-14 (January – June 2014) and 2,685 for FY 2014-15.

3. Assume the caseload projection for the mandatory expansion population is 100 for FY 2013-14 (January – June 2014) and 392 for FY 2014-15.

4. Assume the caseload projection for the optional expansion population is 252 for FY 2013-14 (January – June 2014) and 593 for FY 2014-15.

5. Assume the Units of Service (UOS) is five days of service per patient.

6. The proposed DMC rate for Voluntary Inpatient Detoxification services is $1,490 per day based on the 2012 average Medi-Cal, Selective Provider Contracting Program contract rate.

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

FY 2013-14	Caseload	UOS	Rate	Total
Regular	1,343	5	$ 1,490	$ 10,001,625
Mandatory	100	5	$ 1,490	$ 745,000
Optional	252	5	$ 1,490	$ 1,877,400
				$ 12,624,025

FY 2014-15	Caseload	UOS	Rate	Total
Regular	2,685	5	$ 1,490	$ 20,003,250
Mandatory	392	5	$ 1,490	$ 2,920,400
Optional	593	5	$ 1,490	$ 4,417,850
				$ 27,341,500

8. 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
FY 2013-14	$12,624,000	$9,468,000	$3,156,000
FY 2014-15	$27,342,000	$0	$20,507,000
		$9,468,000	$23,663,000

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 66

9. Funding is 50% General Funds and 50% Federal Financial Participation (FFP). Enhanced FFP is budgeted for the optional caseload.

(Dollars In Thousands)
Cash Basis

	TF	GF	FF
FY 2013-14	$ 9,468	**$ 4,030**	**$ 5,438**
FY 2014-15	$ 23,663	**$ 9,940**	**$ 13,723**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX FF (4260-101-0890)

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DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1723

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,036,000	$3,036,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,036,000	$3,036,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,036,000	$3,036,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement funds for cost settlements to counties and contracted providers for payments related to the Drug Medi-Cal (DMC) services.

Authority:
Welfare & Institutions Code 14124.24 (g)(1)
Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, non-Narcotic Treatment Program providers must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE).

Reimbursement for non-narcotic treatment services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

Reimbursement to Narcotic Treatment Program providers is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 67

Narcotic treatment programs that do not receive federal Substance Abuse Prevention and Treatment block grant funds are not required to submit cost data.

Effective July 1, 2011, the funds to cover the non-federal share of costs were realigned to counties as County Funds (CF).

Reason for Change from Prior Estimate:
Updated actual expenditure data became available for FY 2010-11.

Methodology:

1. The interim cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.

2. Final cost settlements are based on comparing actual expenditures against audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.

3. Costs are estimated to total $3,429,000 for FY 2013-14 and FY 2014-15. In the FY 2011-12, the General Funds (GF) were replaced by County Funds (CF).

FY 2011-12

Settlements	**TF**	**CF**	**FFP**
Regular (Item 103)	$3,207,000	$398,000	$2,808,000
Perinatal (Item 102)	$222,000	($5,000)	$228,000
Total for FY 2013-14	$3,429,000	$393,000	**$3,036,000**

FY 2012-13

Settlements	**TF**	**CF**	**FFP**
Regular (Item 103)	$3,207,000	$398,000	$2,808,000
Perinatal (Item 102)	$222,000	($5,000)	$225,000
Total for FY 2014-15	$3,429,000	$393,000	**$3,036,000**

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

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ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	7/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1724

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$2,607,000
- STATE FUNDS	$0	-$248,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$2,607,000
STATE FUNDS	$0	-$248,000
FEDERAL FUNDS	$0	-$2,359,000

DESCRIPTION

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6 (b)(1); 14021.9 (c); and 14105 (a)
Title 22, California Code of Regulations, Section 51516.1 (a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates for use in FY 2013-14 or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- Narcotic Treatment Program (NTP) – Dosing
- NTP - Individual Counseling
- NTP - Group Counseling
- Intensive Outpatient Treatment, previously Day Care Rehabilitative
- Naltrexone Treatment Service
- Residential Treatment, previously Perinatal Residential
- Outpatient Drug Free (ODF) - Individual Counseling
- ODF- Group Counseling

For FY 2014-15, the DMC reimbursement rate was 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

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 68

can be found in the policy change titled DMC County Admin.

Reason for Change from Prior Estimate:
The CIP deflator changed.

Methodology:
1. The CIP deflator used in calculating the FY 2014-15 DMC rate is 10.6%. This is comprised of:
   - 2.4% for the change from FY 2009-10 to FY 2010-11,
   - 2.8% for the change from FY 2010-11 to FY 2011-12,
   - 1.9% for the change from FY 2011-12 to FY 2012-13,
   - 1.4% for the change from FY 2012-13 to FY 2013-14, and
   - 2.1% assumed for the change from FY 2013-14 to FY 2014-15.

Regular-Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2014-15 Rates *	FY 2014-15 Developed Rates	FY 2014-15 Required Rates
NTP-Dosing	$11.34	10.6%	$12.54	$10.80	$10.80
NTP-Individual	$13.30	10.6%	$14.71	$13.48	$13.48
NTP- Group	$3.14	10.6%	$3.47	$2.91	$2.91
Intensive Outpatient	$61.05	10.6%	$67.52	$56.44	$56.44
Naltrexone	$19.07	10.6%	$21.09	$19.06	$19.06
ODF-Individual	$66.53	10.6%	$73.58	$67.38	$67.38
ODF-Group	$28.27	10.6%	$31.27	$26.23	$26.23

Perinatal-Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2014-15 Rates *	FY 2014-15 Developed Rates	FY 2014-15 Required Rates
NTP-Dosing	$12.21	10.6%	$13.50	$11.79	$11.79
NTP-Individual	$19.04	10.6%	$21.06	$22.52	$21.06
NTP- Group	$6.36	10.6%	$7.03	$8.17	$7.03
Intensive Outpatient	$73.04	10.6%	$80.78	$81.07	$80.78
Residential Treatment	$89.90	10.6%	$99.43	$106.47	$99.43
ODF-Individual	$95.23	10.6%	$105.32	$112.59	$105.32
ODF-Group	$57.26	10.6%	$63.33	$73.53	$63.33

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

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 68

2. The incremental difference between FY 2013-14 required rates and FY 2014-15 required rates are:

Regular-Services		FY 2013-14 Required Rates		FY 2014-15 Required Rates		Incremental Difference
NTP-Dosing		$11.49		$10.80		($0.69)
NTP-Individual		$14.46		$13.48		($0.98)
NTP- Group		$3.27		$2.91		($0.36)
Intensive Outpatient		$62.15		$56.44		($5.71)
Naltrexone		$19.07		$19.06		($0.01)
ODF-Individual		$72.32		$67.38		($4.94)
ODF-Group		$29.39		$26.23		($3.16)

Perinatal-Services		FY 2013-14 Required Rates		FY 2014-15 Required Rates		Incremental Difference
NTP-Dosing		$12.57		$11.79		($0.78)
NTP-Individual		$20.70		$21.06		$0.36
NTP- Group		$6.91		$7.03		$0.12
Intensive Outpatient		$79.39		$80.78		$1.39
Residential Treatment		$97.72		$99.43		$1.71
ODF-Individual		$103.52		$105.32		$1.80
ODF-Group		$62.24		$63.33		$1.09

3. The cost estimate is developed by the following:

   Caseload x Units of Service (UOS) x Rates

4. The incremental rate change on an accrual basis is shown below:

Regular (Program 20)	
Narcotic Treatment	($7,168,060)
Intensive Outpatient	($7,508,261)
Outpatient Drug Free	($8,219,089)
Residential Treatment	$2,611,561
Total for Regular	($20,283,849)
Perinatal (Program 25)	
Narcotic Treatment	($4,278)
Intensive Outpatient	$58,091
Outpatient Drug Free	$14,926
Perinatal	$81,676
Total for Perinatal	$150,416

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

	Accrual	FY 2013-14	FY 2014-15
Regular	($20,283,849)	($15,212,887)	($5,070,962)
Perinatal	$150,416	$112,812	$37,604
Total	($20,133,433)	($15,100,075)	($5,033,358)

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ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 68

6. The annual rate adjustment for FY 2014-15 is:

	Total	GF	FFP	County Funds*
FY 2013-14	($15,100,075)	($744,368)	($7,077,628)	($7,278,079)
FY 2014-15	($5,033,358)	**($248,123)**	**($2,359,209)**	($2,426,027)

*****County funds are not budgeted.

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

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SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	2/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1458

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$293,819,000	$107,898,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$293,819,000	$107,898,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$293,819,000	$107,898,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institution Code 14723

Interdependent Policy Changes:
Not Applicable

Background:
State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

The Supplemental Payment Program is pending approval from the Centers for Medicare and Medicaid Services (CMS).

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

Methodology:
1. The unreimbursed costs for county-operated providers was calculated based on the difference between the county operated provider's gross allowable cost and the gross schedule of statewide maximum allowance (SMA).

2. The amount of unreimbursed costs was increased by the ratio of county costs to total mental health plan costs to account for unreimbursed costs for contract providers.

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SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 71

3. The FY 2008-09 estimates were developed using the final filed cost reports received from each county mental health plan.

4. The FY 2009-10 estimates were developed using the final filed cost reports received from each county and are still under Department review.

5. Assume the FY 2010-11 supplemental payments will increase by 10% from the payment for FY 2009-10 and the FY 2011-12 supplemental payments will increase by 10% from the payment for FY 2010-11.

(Dollars In Thousands)

	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2008-09 FFP	$51,463	$12,079	$63,542
FY 2009-10 FFP	$89,172	$20,484	$109,656
FY 2010-11 FFP	$98,089	$22,532	$120,621
Total for FY 2013-14	$238,724	$55,095	**$293,819**
FY 2011-12 FFP	$107,898	$0	$107,898
Total for FY 2014-15	$107,898	**$0**	**$107,898**

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

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ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1759

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$124,190,000	$133,477,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$124,190,000	$133,477,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$124,190,000	$133,477,000

DESCRIPTION

Purpose:
This policy change estimates the elimination of the state maximum rates for Medi-Cal specialty mental health services.

Authority
Assembly Bill 1297 (Chapter 651, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The Welfare and Institution Code, sections 5720 and 5724, limited reimbursement of specialty mental health services to the state maximum rates. The state maximum rate is a schedule of maximum allowances (SMA) for specialty mental health services. AB 1297 amended W& I Code, sections 5720 and 5724 to change the manner in which specialty mental health services are reimbursed. AB 1297 requires the Department to reimburse mental health plans based upon the lower of their certified public expenditures or the federal upper payment limit. The federal upper payment limit will be equal to the aggregate allowable cost or customary charge for all specialty mental health services provided by the mental health plan and its network of providers. These changes to the reimbursement methodology will result in an increase of federal reimbursement to mental health plans for specialty mental health services.

Reason for Change from Prior Estimate:
The change is due to an increase of 7.69% for payments made each year and the payment rates of claims paid during FY 2013-14.

Methodology:
1. The costs are developed using FY 2009-10 final filed cost reports received from each county.

2. The costs in excess of the SMA that was not reimbursed in the past but are eligible for

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 72

reimbursement under AB 1297, is budgeted in this policy change.

3. Assume each year there will be an increase of 7.69% from the payment for FY 2009-10, which is the most recent fiscal year for which cost reports are available.

4. The accrual estimates are:

(In Thousands)

FY 2012-13	TF	FFP	M-CHIP	County
Children	$129,552	$63,016	$2,288	$64,248
Adults	$104,440	$52,220	$0	$52,220
Total	$233,992	$115,236	$2,288	$116,468

(In Thousands)

FY 2013-14	TF	FFP	M-CHIP	County
Children	$139,517	$67,863	$2,464	$69,190
Adults	$112,474	$56,237	$0	$56,237
Total	$251,991	$124,100	$2,464	$125,427

(In Thousands)

FY 2014-15	TF	FFP	M-CHIP	County
Children	$150,249	$73,083	$2,654	$74,512
Adults	$121,126	$60,563	$0	$60,563
Total	$271,375	$133,646	$2,454	$135,075

5. On a cash basis for FY 2013-14, the Department will be paying 29% of FY 2012-13 claims and 71% of FY 2013-14 claims. In FY 2014-15, the Department will be paying 29% of FY 2013-14 claims and 71% of FY 2014-15 claims.

(In Thousands)

FY 2012-13	TF	FFP	M-CHIP*	County
Children	$37,817	$18,522	$664	$18,631
Adults	$30,288	$15,144	$0	$15,144
Total	$68,105	$33,666	$644	$33,775

(In Thousands)

FY 2013-14	TF	FFP	M-CHIP*	County
Children	$99,057	$48,183	$1,749	$49,125
Adults	$79,857	$39,928	$0	$39,929
Total	$178,914	$88,111	$1,749	$89,054
Total FY 2013-14	$247,019	**$121,777**	**$2,413**	$122,829

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ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 72

(In Thousands)

FY 2013-14	TF	FFP	M-CHIP*	County
Children	$40,460	$19,680	$715	$20,065
Adults	$32,617	$16,309	$0	$16,308
Total	$73,077	$35,989	$715	$36,373

(In Thousands)

FY 2014-15	TF	FFP	M-CHIP*	County
Children	$106,676	$51,889	$1,884	$52,903
Adults	$85,999	$43,000	$0	$42,999
Total	$192,675	$94,889	$1,884	$95,902
Total FY 2014-15	$265,752	**$130,878**	**$2,599**	$132,275

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

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TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1719

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$32,619,000	$41,938,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$32,619,000	$41,938,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$32,619,000	$41,938,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for specialty mental health benefits associated with transitioning the Healthy Families Program (HFP) subscribers into the Medi-Cal program.

Authority:
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 transitions all HFP subscribers into the Medi-Cal program using a phased-in approach beginning January 2013. Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) enrollees are carved out and provided by county mental health plans. The Medi-Cal program does not have an “SED carve-out,” but it does carve out from Medi-Cal managed care plans any mental health services beyond what a primary care physician can provide within their scope of practice; this includes Medi-Cal specialty mental health services. Children transitioning from the HFP to Medi-Cal will have access to the carved-out Medi-Cal specialty mental health services provided by county mental health plans if they meet medical necessity criteria for those services. County mental health plans are eligible to claim FFP through the Certified Public Expenditure (CPE) process.

The first group of children transitioned from HFP to Medi-Cal on January 1, 2013. The remaining groups will transition to Medi-Cal in phases throughout calendar year 2013 and upon CMS approval for each transition phase.

HFP subscribers that transition to the Medi-Cal program are considered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible and can receive the full array of Medi-Cal specialty mental health services based on medical necessity and their mental health needs.

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TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 73

Reason for Change from Prior Estimate:
Revision based on the updates to HFP caseload.

Methodology:

1. Beginning January 1, 2013, HFP subscribers transitioned to Medi-Cal.

2. The majority of mental health services provided to current SED enrollees will continue under the Medi-Cal specialty mental health services. As such, the current SED expenditures will shift from the HFP Families – SED policy change to the Children's SMHS policy changes.

3. Additional EPSDT clients may be served by the mental health plans as a result of changing from SED criteria to Medi-Cal medical necessity criteria, which will increase utilization of outpatient services.

4. Additional psychiatric inpatient services will be provided by the mental health plans that were previously covered by the HFP managed care plans.

(In Thousands)

	TF	FFP	County
SED Services	$26,878	$17,471	$9,407
Outpatient	$37,814	**$24,579**	$13,235
Inpatient	$12,369	**$8,040**	$4,329
FY 2013-14	$77,061	$50,090	$26,971

(In Thousands)

	TF	FFP	County
SED Services	$35,540	$23,101	$12,439
Outpatient	$48,618	**$31,602**	$17,016
Inpatient	$15,902	**$10,336**	$5,566
FY 2014-15	$100,060	$65,039	$35,021

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

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KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1718

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$27,955,000	$26,751,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$27,955,000	$26,751,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$27,955,000	$26,751,000

DESCRIPTION

Purpose:
This policy change estimates the increase in costs due to the *Katie A. v. Diana Bontá* lawsuit.

Authority:
Katie A. v. Diana Bontá

Interdependent Policy Changes:
Not Applicable

Background:
On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. Since October 13, 2011, the parties have met with the Special Master to develop a plan for settlement implementation. As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive an increase in existing services that will be provided in a more intensive and effective manner. In this context, these existing services are referred to as Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC). The ICC and IHBS were available effective January 1, 2013, and TFC is anticipated to be available beginning January 1, 2014.

Reason for Change from Prior Estimate:
This estimate has been updated for an increase in the lag of claim payments.

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KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER: 74

Methodology:

1. The *Katie A*. cost estimate is based on two factors:

   - An increase in the penetration rate of children receiving specialty mental health services within the *Katie A*. subclass of clients; and

   - An increase in the cost of services per client for existing clients due to the availability of more intensive services.

2. This estimate assumes the increase in the cost of services per client for ICC, IHBS, and TFC.

3. The estimated annual cost for new clients is $38,830,000 and the estimated annual increase in cost for existing clients is $14,672,000, giving a total annual cost of $53,502,000. These amounts are based on an accrual basis.

4. Assume the additional services began January 1, 2013.

5. In FY 2012-13 assume the accrual estimate is half of the full year costs.

   $53,502,000 ÷ 12 months x 6 months = $26,751,000

6. Based on historical claims received, assume 71% of the each fiscal year claims will be paid in the year the services occur. The remaining 29% is paid in the following year. Due to startup billing delays for FY 2012-13 services, assume 67% of the claims are paid in FY 2013-14.

(In Thousands)

Cash Estimate	TF	FFP	County
FY 2012-13	$17,924	$8,962	$8,962
FY 2013-14	$37,986	$18,993	$18,993
FY 2013-14	$55,910	**$27,955**	$27,955
FY 2013-14	$15,516	$7,758	$7,758
FY 2014-15	$37,986	$18,993	$18,993
FY 2014-15	$53,502	**$26,751**	$26,751

Funding:

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

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HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1712

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$18,731,000	$18,307,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,731,000	$18,307,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$18,731,000	$18,307,000

DESCRIPTION

Purpose:
This policy change estimates the costs of providing services to Healthy Families enrollees who are Seriously Emotionally Disturbed (SED).

Authority:
California Insurance Code 12693.61 and 12694.1

Interdependent Policy Changes:
Not Applicable

Background:
The Healthy Families Program (HFP) provides low cost insurance for eligible children under the age of 19 whose families:

- Do not have health insurance,
- Do not qualify for zero share of cost Medi-Cal,
- Income is at or below 250 percent of the federal poverty level.

Mental health services for the HFP subscribers who are SED are “carved-out” of the HFP managed care health plans’ array of covered services and are provided by county mental health departments. County mental health departments are responsible for the provision and payment of all treatment of SED conditions, with the exception of the first thirty days of psychiatric inpatient services per benefit year, which remain the responsibility of the HFP health plan. This covered benefit is referred to as the “HFP SED benefit.”

When a county mental health department assumes responsibility for the treatment of the HFP subscriber’s SED condition, it can submit claims to obtain federal reimbursement for the services. County mental health departments receive 65% FFP reimbursement for services provided to HFP subscribers and pay for the 35% match with realignment dollars or other local funds.

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 75

On January 1, 2013, HFP ceased to enroll new subscribers and the current HFP subscribers were phased into the Medi-Cal program.

Reason for Change from Prior Estimate:
There is a decrease in FY 2013-14 expenditures due to updated claims data and a decrease in FY 2012-13 approved claims as a result of the HFP enrollees transition to Medi-Cal.

Methodology:

1. The costs are developed using 69 months of Short-Doyle/Medi-Cal (SD/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.

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. Medi-Cal Specialty Mental Health programs costs are shared between federal funds (FFP) and a county match. State Children's Health Insurance Program (S-CHIP) claims are eligible for federal reimbursement of 65%.

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

(Dollars In Thousands)

Accrual Estimate	TF	FFP	County
FY 2011-12	$31,558	$20,513	$11,045
FY 2012-13	$29,245	$19,009	$10,236
FY 2013-14	$28,609	$18,596	$10,013
FY 2014-15	$27,973	$18,182	$9,791

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.

(Dollars In Thousands)

Cash Estimate	TF	FFP	County
FY 2011-12	$316	$205	$111
FY 2012-13	$8,189	$5,323	$2,866
FY 2013-14	$20,312	$13,203	$7,109
TOTAL FY 2013-14	$28,817	**$18,731**	$10,086

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HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 75

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.

(Dollars In Thousands)

Cash Estimate	TF	FFP	County
FY 2012-13	$292	$190	$102
FY 2013-14	$8,011	$5,207	$2,804
FY 2014-15	$19,861	$12,910	$6,951
TOTAL FY 2014-15	$28,164	**$18,307**	$9,857

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

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INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	1/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1805

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$12,400,000	$24,800,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,400,000	$24,800,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$12,400,000	$24,800,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for mobile crisis support teams and triage personnel to enhance mental health services for community wellness.

Authority:
SB 82 (Chapter 34, Statutes of 2013) Investment in Mental Health Wellness Act of 2013

Interdependent Policy Changes:
Not Applicable

Background:
The Investment in Mental Health Wellness Act of 2013 specifies to add 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds over the next two years to expand community-based resources and capacity. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders. The California Health Facilities Financing Authority within the State Treasurer's Office will implement grant programs for one-time funding to build supporting infrastructure. The anticipated federal fund reimbursements for mobile crisis support services of $2.8 million annually may begin in January 2014, depending on approved grant applications.

This Act also specifies to add at least 600 triage personnel over the next two years to assist individuals in gaining access to medical, specialty mental health care, alcohol and drug treatment, social, educational, and other services. The Mental Health Services Oversight and Accountability Commission will implement an allocation process based on funding applications for Mental Health Services Act funds totaling $32 million. The majority of the triage personnel costs are assumed to be Medi-Cal reimbursable. The total estimated federal reimbursement is $22 million annually. The triage services may begin in January 2014, depending on approved funding applications.

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INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER: 76

Reason for Change from Prior Estimate:
The federal fund reimbursements expenditures have been updated to begin January 2014.

Methodology:
1. The federal portion is shown below:

(Dollars In Thousands)

	FY 2013-14	FY 2014-15
Mobile Crisis Teams	$1,400	$2,800
600 Triage Personnel	$11,000	$22,000
Total	**$12,400**	**$24,800**

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

OVER ONE-YEAR CLAIMS

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1717

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,000,000	$3,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,000,000	$3,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,000,000	$3,000,000

DESCRIPTION

Purpose:
This policy change estimates the cost of claims that are submitted by county mental health plans for late eligibility determinations.

Authority:
Title 22, California Code of Regulations 50746 and 51008.5
Welfare & Institutions Code 14680-14685.1
Specialty Mental Health Services Consolidation Waiver

Interdependent Policy Changes:
Not Applicable

Background:
County mental health plans have begun submitting Medi-Cal specialty mental health service claims for clients with Letters of Authorization for late eligibility determinations. When an over one-year claim is determined as eligible by the Department, the county has 60 days to submit the claim for payment.

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

Methodology:
1. One-year claims are based on actual claims received from the counties.

(In Thousands)

	TF	FFP	County
FY 2013-14	$6,000	**$3,000**	$3,000
FY 2014-15	$6,000	**$3,000**	$3,000

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

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SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT

REGULAR POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1716

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,270,000	$2,270,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,270,000	$2,270,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,270,000	$2,270,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Solano County exercising their right to assume responsibility for providing or arranging for Medi-Cal specialty mental health services (SMHS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Prior to FY 2012-13, the Medi-Cal managed care program, Partnership Health Plan, “carved in” SMHS for Solano County.

Effective July 1, 2012, the Solano County mental health plan terminated its contractual relationship with Partnership Health Plan and assumed responsibility to provide or arrange for the provision of the full array of Medi-Cal SMHS to eligible Medi-Cal beneficiaries, with the exception of Partnership Health Plan enrollees that are Kaiser Permanente members. Partnership Health Plan will continue to capitate payments for Kaiser Permanente SMHS provided to Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership Health Plan and Kaiser Permanente.

The Medi-Cal managed care contract was reduced for the Solano County mental health services component. The 2011 Realignment funding for Solano County was increased by the amount needed ($2,769,000) for services for all Medi-Cal beneficiaries in anticipation of Solano County assuming the entire provision of services role. Since it has not yet assumed responsibility for the Kaiser Permanente members, Solano County will provide the Department with the portion of its 2011 Realignment funds associated with the capitated amount provided by the Department to Partnership Health Plan for SMHS for Kaiser Permanente members ($499,000).

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SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT

REGULAR POLICY CHANGE NUMBER: 78

Reason for Change from Prior Estimate:
The estimate is reduced by approximately $1 million total funds (TF) for the annual amount paid to Kaiser Permanente in capitation payments. This amount is instead paid through the Medi-Cal Managed Care contract.

Methodology:
1. Partnership Health Plan has identified that it pays out approximately $4.5 million TF to Solano County Mental Health Plan in annual capitation payments for SMHS.

(In Thousands)

	TF	FFP	County
FY 2013-14	$4,540	**$2,270**	$2,270
FY 2014-15	$4,540	**$2,270**	$2,270

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

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SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	1/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1660

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$7,204,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$7,204,000	$0
FEDERAL FUNDS	-$7,204,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of federal financial participation (FFP) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:
Title 42, United States Code (USC) 1396b(d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
During the audit and cost settlement process, the Department identified overpayments to Siskiyou County Mental Health Plan as a result of improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FFP to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department in the amount of $200,000 per year until it fulfills its obligation for repayment. The County submitted its first payment of $200,000 in August 2012.

Reason for Change from Prior Estimate:
FY 2012-13 repayment amounts were moved to FY 2013-14 and the total repayment amount was reduced to account for the FFP due to the county during the cost settlement. Also, a repayment amount of $1,131,000 was added as a result of a chart review audit.

Methodology:
1. The Department began making repayments to CMS in January 2012.

2. In FY 2013-14, a repayment amount of $1,131,000 was added as a result of a chart review audit disallowing service claims for Heal Therapy.

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SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 79

3. Siskiyou County will reimburse the GF $200,000 annually. As a result, of the total FFP repayment of $7,204,000 that the Department will make in FY 2013-14, $7,004,000 will be paid from the GF. Reimbursements are shown in the Management Summary.

Date of Overpayment Discovery	FY 2013-14 Repayment		FY 2014-15 Repayment	
8/4/2011	$2,090,000			
11/15/2011	$ 586,000			
12/21/2011	$ 95,000			
3/26/2012	$443,000			
1/30/2013	$2,859,000			
5/30/2013	$1,131,000			
Total:	**$7,204,000**	GF		
	($200,000)		**($200,000)**	Reimbursement

Funding:
GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$6,000,000	$6,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$6,000,000	$6,000,000
FEDERAL FUNDS	-$6,000,000	-$6,000,000

DESCRIPTION

Purpose:
This policy change estimates the cost of federal financial participation (FFP) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs).

Authority:
Title 42, Code of Federal Regulations 435.1009
Welfare & Institutions Code 14053.3

Interdependent Policy Changes:
PC 82 Reimbursement in IMD Ancillary Services Costs

Background:
Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for state or federal reimbursement. These ancillary services are to be county-funded. The Department has instructed providers to bill the responsible county as indicated in the Medi-Cal Eligibility Data System (MEDS). Identifiers are currently not available in MEDS to indicate whether a Medi-Cal beneficiary is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may deny any claims that are ineligible for reimbursement for this reason. The Department uses data from the mental health Client Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FFP, as required by the Centers for Medicare & Medicaid Services (CMS). This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

This policy change budgets the costs for the Department to repay the FFP portion of IMD costs to the CMS. A separate policy change, called Reimbursement in IMD Ancillary Services Costs, budgets the

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 80

total reimbursement to be collected from the counties to repay the Department and CMS.

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

Methodology:

1. The FFP repayment for FY 2013-14 and FY 2014-15 is:

(Dollars in Thousands)

Services Received	FY 2013-14	FY 2014-15
10/01/10 - 09/30/11	$6,000	$0
10/01/11 - 09/30/12	$0	$6,000
Total	**$6,000**	**$6,000**

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

CHART REVIEW

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1714

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,475,000	-$418,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,475,000	-$418,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,475,000	-$418,000

DESCRIPTION

Purpose:
This policy change estimates the recoupments due to the Department from disallowed claims. The disallowed claims are the result of the on-site chart reviews of inpatient and outpatient mental health providers.

Authority:
Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:
Not Applicable

Background:
Since January 2005, the Department has been conducting on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries.

Reason for Change from Prior Estimate:
Fiscal estimates for FY 2013-14 includes recoupments from prior years.

Methodology:
1. The FY 2013-14 estimate includes recoupments from FY 2011-12, FY 2012-13, and FY 2013-14.

2. The FY 2014-15 estimate includes recoupments from FY 2013-14 and FY 2014-15.

(In Thousands)

	TF	FFP
FY 2013-14	**($1,475)**	**($1,475)**
FY 2014-15	**($418)**	**($418)**

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

REIMBURSEMENT IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1711

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$12,000,000	-$12,000,000
- STATE FUNDS	-$12,000,000	-$12,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$12,000,000	-$12,000,000
STATE FUNDS	-$12,000,000	-$12,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change reflects the General Fund (GF) reimbursement for inappropriately claimed Medi-Cal ancillary services provided to beneficiaries in Institutions for Mental Diseases (IMDs).

Authority:
Title 42, Code of Federal Regulations, section 435.1009
Welfare & Institutions Code, section 14053.3

Interdependent Policy Changes:
Not Applicable

Background:
Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for state or federal reimbursement. These ancillary services are to be county-funded. The Department has instructed providers to bill the responsible county, as indicated in the Medi-Cal Eligibility Data System (MEDS). Identifiers are currently not available in MEDS to indicate whether a Medi-Cal beneficiary is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may deny any claims that are ineligible for reimbursement for this reason. The Department uses data from the mental health Client Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FFP, as required by the Centers for Medicare & Medicaid Services (CMS). This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be recovered from the counties per section 14053.3 of WIC. The Department will begin the recovery process in FY 2013-14 beginning with service FY 2008-09, which is the budget year section 14053.3 was added per AB 1183 (Chapter 758, Statutes of 2008).

This policy change budgets the total reimbursement to be collected from the counties to repay the

REIMBURSEMENT IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 82

Department and CMS. A separate policy change, called IMD Ancillary Services, budgets for the Department to repay the FFP portion of IMD costs to the CMS.

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

Methodology:
1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

2. In FY 2013-14, the Department expects to collect costs beginning FY 2008-09. These costs will be determined using the inappropriately paid claims for IMD ancillary services and charged to the county responsible for the beneficiary as indicated in MEDS.

3. The GF reimbursement includes repayment for both FFP and any state funds paid for the ancillary services provided to residents of IMDs.

(In Thousands)

Dates of Service	FY 2013-14	FY 2014-15
FY 2008-09	($12,000)	$0
FY 2009-10	$0	$(12,000)
Total	**($12,000)**	**($12,000)**

Funding:
100% General Fund (4260-101-0001)
Reimbursement (4260-610-0995)

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INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1713

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$41,760,000	$0
- STATE FUNDS	$27,777,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$41,760,000	$0
STATE FUNDS	$27,777,000	$0
FEDERAL FUNDS	-$69,537,000	$0

DESCRIPTION

Purpose:
This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:
Welfare & Institution Code 14705(c)
Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim settlements to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlement is completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

Reason for Change from Prior Estimate:
FY 2013-14 expenditures have been updated to include new final cost settlements, unpaid interim and final cost settlements from FY 2012-13, and updated FY 2009-10 interim cost settlement amounts.

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INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83

Methodology:

1. Interim cost settlements are based upon the difference between each county MHP's filed cost report and the payments they received from the Department.

2. Final cost settlement is based upon the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for services, administration, utilization review/quality assurance, and mental health Medi-Cal administrative activities are each determined separately.

(Dollars In Thousands)

	Underpaid	Overpaid	Net
Interim Settlement (FY 2008-09)			
Children and Adults	$0	($24,540)	($24,540)
M-CHIP*	$69	($1,419)	($1,350)
Healthy Families*	$1,307	($2,353)	($1,046)
Interim Settlement (FY 2009-10)			
Children and Adults	$56,470	($76,075)	($19,605)
M-CHIP*	$2,983	($2,052)	$931
Healthy Families*	$89	($3,886)	($3,797)
Interim Settlement (FY 2010-11)			
Children and Adults	$51,645	($73,696)	($22,051)
M-CHIP*	$802	($2,646)	($1,844)
Healthy Families*	$1,051	($1,952)	($901)
Final Settlement (Multi-Years)			
Children and Adults	$46,576	($42,259)	$4,317
M-CHIP*	$959	($219)	$740
Healthy Families*	$1,436	($1,827)	($391)
Total FY 2013-14	$163,387	($232,924)	($69,537)

4. Cost settlements prior to realignment may consist of General Fund (GF) and federal financial participation (FFP).

(Dollars In Thousands)

	TF	GF	FFP
Children and Adults	($34,102)	$27,777	($61,879)
M-CHIP*	($1,523)	$0	($1,523)
Healthy Families*	($6,135)	$0	($6,135)
Total FY 2013-14	**($41,760)**	**$27,777**	**($69,537)**

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83

Funding:
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)*
100% General Fund (4260-101-0001)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2011
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1578

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,495,397,000	$0
- STATE FUNDS	$2,338,785,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,495,397,000	$0
STATE FUNDS	$2,338,785,500	$0
FEDERAL FUNDS	$3,156,611,500	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP is effective November 1, 2010, through December 31, 2013, under the BTR and consists of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE will cover eligible individuals with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the HCCI (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use the following methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs),
- Intergovernmental Transfers (IGTs) for capitation rates payments, and
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

The Department has used the CI cost claiming protocol for the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) as the basis for payments made on claims for dates of service from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 84

Conditions under the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013. The Department makes payments for dates of services beginning the second quarter of FY 2011-12 based on the new CPE cost claiming protocol.

The Department submitted the new cost claiming protocol for claims based on capitation rates for health care services provided to only MCE enrollees, and the capitated rate contract amendments to CMS in April 2012. The Department also submitted the letters of Certification of Capitation Rates to CMS in August 2012, for the following eight local LIHPs: Alameda, Los Angeles, Kern, Riverside, San Bernardino, San Francisco, Santa Clara, and San Mateo.

Upon CMS approval of the capitation rate claiming protocol, the capitated rates, and the capitated rate contract amendments, these local LIHPs will receive payments based on approved capitation rates for health care services provided to their MCE population effective retroactively to July 1, 2011. Currently CMS has approved the capitation rates for these local LIHPs, but not approved the capitation rate protocol and the contract amendments.

The local LIHPs with CMS's approval to use the capitation payment mechanism for federal reimbursement of the MCE component of their program will continue to use CPEs to claim for reimbursement of their allowable health care services that are excluded from their capitation rates. The remaining local LIHPs will only use CPEs to claim for federal reimbursement. The MCE program is not subject to a federal funding cap.

Reason for Change from Prior Estimate:

- Estimates have been revised due to increased enrollment.
- FY 2011-12 payments scheduled to be paid in FY 2012-13 were delayed to FY 2013-14.
- Payment reconciliations for FY 2010-11 will be paid in FY 2013-14.

Methodology:

1. The eight local LIHPs with approved capitation rates will continue to use CPEs for claiming federal reimbursement until CMS approves all capitation rate reimbursement documents. Once CMS approves the documents, the prior CPE-based payments retroactive to July 1, 2011 will be reconciled with the new capitation rate payments and the CPEs for excluded services.

2. Assume the capitation rates payments and reconciliation for FY 2011-12 payments to the new capitated rates will occur in FY 2013-14.

3. The payment reconciliation may result in an overpayment or underpayment in FFP. The Department will recover the appropriate amount of FFP from the affected local LIHPs.

4. Local LIHPs with county-owned FQHCs will claim their allowable FQHC costs by using IGTs as the nonfederal share of the payments. That will be retroactive to July 1, 2011 or their LIHP implementation date if later.

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BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 84

The estimated MCE payments on a cash basis are:

(Dollars In Thousands)

FY 2013-14	TF	IGT CAP	IGT-FQHC	FFP	CPE*
2010-11 (CPEs)	$13,980			$13,980	$13,980
2011-12 (CPEs)	$11,476			$11,476	$11,476
2011-12 (IGT-FQHC)	$107,769		$53,885	$53,885	
2011-12 (IGT CAP)	$992,917	$496,459		$496,459	
2012-13 (CPEs)	$417,005			$417,005	$417,005
2012-13 (IGT-FQHC)	$107,769		$53,885	$53,885	
2012-13 (IGT CAP)	$2,070,908	$1,035,454		$1,035,454	
2013-14 (CPEs)	$375,366			$375,366	$375,366
2013-14 (IGT-FQHC)	$53,884		$26,942	$26,942	
2013-14 (IGT CAP)	$1,344,324	$672,162		$672,162	
Total**	**$5,495,397**	**$2,204,075**	**$134,711**	**$3,156,612**	$817,827

Funding:
LIHP IGT Fund (4260-607-8502)
100% Title XIX (4260-101-0890)

*Not included in TF.
**Amounts may differ due to rounding.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1073

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,599,070,000	$1,702,746,000
- STATE FUNDS	$344,527,000	$535,885,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,599,070,000	$1,702,746,000
STATE FUNDS	$344,527,000	$535,885,000
FEDERAL FUNDS	$1,254,543,000	$1,166,861,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.6 and 14166.16
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The 2013-14 and 2014-15 DSH allotments are estimated to be $1,166,862,000 before applying the Affordable Care Act (ACA) reduction.

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits.

- Private DSH hospitals, under the Special Terms and Conditions, are allocated a total of $160.00 from the federal DSH allotment and State General Fund (GF) each demonstration year. All DSH

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 85

eligible Private hospitals receive a pro-rata share of the $160.00.

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD.

Pursuant to the ACA, DSH allotments will be reduced beginning FY 2013-14 through FY 2019-20. The reductions for each state will be determined by the Centers for Medicare and Medicaid Services (CMS). See the Disproportionate Share Hospital Reduction policy change for more information.

Reason for Change from Prior Estimate:
The overall decrease is due to data changes. The 2010-11 actual final payment is decreased slightly due to hospital data changes. The 2011-12 and 2012-13 changes are due to CPE and IGT recoupments being reflected. The 2013-14 decrease is due to a decrease in the estimated IGTs.

Methodology:
It is assumed that the DSH payments will be made as follows on a cash basis:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF****	**FF**	**IGT***
DSH 2010-11	$1,834	$917	$917	$0
DSH 2011-12	($6,081)	$1,449	$91,712	($99,242)
DSH 2012-13	$42,466	$1,229	$92,292	($51,055)
DSH 2013-14	$1,560,851	$10,083	$1,069,623	$481,145
	$1,559,070	**$13,678**	**$1,254,544**	**$330,848**
FY 2014-15				
DSH 2013-14	$141,895	$917	$97,238	$43,740
DSH 2014-15	$1,560,851	$10,083	$1,069,623	$481,145
	$1,702,746	**$11,000**	**$1,166,861**	**$524,885**

Funding:
100% Demonstration DSH Fund (4260-601-7502)
50% MIPA Fund / 50% Title XIX (4260-606-0834/0890)*
50% GF / 50% Title XIX (4260-101-0001/0890)**

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	3/2011
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1570

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,485,648,000	$1,892,310,000
- STATE FUNDS	$742,824,000	$946,155,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,485,648,000	$1,892,310,000
STATE FUNDS	$742,824,000	$946,155,000
FEDERAL FUNDS	$742,824,000	$946,155,000

DESCRIPTION

Purpose:
This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's Designated Public Hospitals' (DPH) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.77
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010. The BTR establishes the DSRIP. AB 1066 provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payments to DPHs.

There are four areas for which funding is available under the DSRIP in the Medi-Cal program:

(1) Infrastructure Development
(2) Innovation and Redesign
(3) Population-focused Improvement
(4) Urgent Improvement in Care

DPHs submitted their DSRIP proposal for approval and are paid based on meeting milestones. DPHs provide the non-federal share of their DSRIP through IGTs.

The total federal funding for DSRIP shall not exceed total computable expenditures of $6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable Federal Medical Assistance Percentage (FMAP) of annual total computable expenditure limits as follows:

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 86

(Dollars in Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	$ 1,006,880	$ 591,601
2011-12	$ 1,300,000	$ 650,000
2012-13	$ 1,400,000	$ 700,000
2013-14	$ 1,400,000	$ 700,000
2014-15	$ 1,400,000	$ 700,000

Reason for Change from Prior Estimate:
Updated program expenditures.

Methodology:

1. In DY 2011-12 and subsequent demonstration years, payments are expected to be made in March of the same fiscal year and September of the subsequent fiscal year.

2. Any hospitals that did not achieve full funding in March and September as noted above for DY 2011-12 can achieve the remaining funding in September 2013 and March 2014.

3. It is anticipated that hospitals will achieve 95% of the DY 2012-13 funding as noted above by March 2014. The remaining 5% is anticipated to be achieved by September 2014.

4. It is anticipated that hospitals will achieve 55% of the DY 2013-14 funding in the March 2014 payment and 98% of the remaining amount available by the March 2015 payment.

5. It is anticipated that hospitals will achieve 90% of the DY 2014-15 funding in the March 2015 payment.

6. DSRIP payments are estimated to be:

(Dollars in Thousands)

		TF	FF	IGT
FY 2013-14				
	DY 2011-12	$5,400	$2,700	$2,700
	DY 2012-13	$710,248	$355,124	$355,124
	DY 2013-14	$770,000	$385,000	$385,000
	Total	**$1,485,648**	**$742,824**	**$742,824**
FY 2014-15				
	DY 2012-13	$3,570	$1,785	$1,785
	DY 2013-14	$628,740	$314,370	$314,370
	DY 2014-15	$1,260,000	$630,000	$630,000
	Total	**$1,892,310**	**$946,155**	**$946,155**

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 86

Funding:
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)
50% Title XIX FF (4260-101-0890)

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1071

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$603,508,000	$534,994,000
- STATE FUNDS	$301,754,000	$267,497,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$603,508,000	$534,994,000
STATE FUNDS	$301,754,000	$267,497,000
FEDERAL FUNDS	$301,754,000	$267,497,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the private Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously in effect for the 2004-05 fiscal year. These payments along with $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute.

The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

Pursuant to the Affordable Care Act (ACA), DSH allotments will be reduced beginning FY 2013-14 through FY 2019-20. The reductions for each state will be determined by the Centers for Medicare and Medicaid Services (CMS). The private DSH replacement payments are affected because, as required by SB 1100, the methodology to determine the DSH replacement payments is based on the DSH allotment. See the Private DSH Replacement Payment Reduction policy change for more information.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 87

Reason for Change from Prior Estimate:
The change is due to the addition of the remaining balance of 2009-10 and 2010-11 DSH replacement payments to FY 2013-14. Also, 2012-13 and 2013-14 DSH replacement payments are expected to be higher than prior estimate.

Methodology:

1. The remaining balance of 2009-10 and 2010-11 final payments are assumed to be paid in FY 2013-14.

2. Approximately one month of 2011-12 and 2012-13 payments are assumed to be paid in FY 2013-14.

3. SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by $10.5 million TF ($5.25 million GF) in 2013-14.

4. 11 months of 2013-14 payments are assumed to be paid in FY 2013-14 and one month of 2013-14 payments in FY 2014-15. The prorated 2013-14 SB 335 reductions are $9,625,000 TF ($4,812,500 GF) in FY 2013-14 and $875,000 TF ($437,500 GF) in FY 2014-15.

5. 11 months of 2014-15 payments are assumed to be paid in FY 2014-15.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2013-14	**TF**	**GF**	**FF**
2009-10	$1,544,000	$772,000	$772,000
2010-11	$46,021,000	$23,010,500	$23,010,500
2011-12	$29,482,000	$14,741,000	$14,741,000
2012-13	$44,873,000	$22,436,500	$22,436,500
2013-14	$491,213,000	$245,606,500	$245,606,500
SB 335	($9,625,000)	($4,812,500)	($4,812,500)
Net	$481,588,000	$240,794,000	$240,794,000
Total FY 2013-14	**$603,508,000**	**$301,754,000**	**$301,754,000**
FY 2014-15			
2013-14	$44,656,000	$22,238,000	$22,328,000
SB 335	($875,000)	($437,500)	($437,500)
Net	$43,781,000	$21,890,500	$21,890,500
2014-15	$491,213,000	$246,606,500	$245,606,500
Total FY 2014-15	**$534,994,000**	**$267,497,000**	**$267,497,000**

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 87

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

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	11/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1573

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$317,250,000	$242,250,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$317,250,000	$242,250,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$317,250,000	$242,250,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) for uncompensated care provided to individuals with no source of third party coverage for the services they receive.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.71
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after November 1, 2010 until October 31, 2015, based on the Special Terms and Conditions of the BTR, a new SNCP was established to support the provision of services to the uninsured. The SNCP is to be claimed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in Demonstration Year (DY) 6 of the BTR demonstration. This policy change estimates the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

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

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 88

Methodology:

1. Interim payments are made in four payments to the DPHs on a quarterly basis. The fourth quarter payment is split into two payments. Payments are made in October, January, April, June, and July. The June payment includes the months of April and May, while the July payment is for the month of June.

2. The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands) Demonstration Year	State-Only Funded Programs	Due to DPHs
2010-11 (DY 6)	$400,000	$565,422
2011-12 (DY 7)	$400,000	$436,000
2012-13 (DY 8)	$400,000	$386,000
2013-14 (DY 9)	$400,000	$311,000
2014-15 (DY 10)	$400,000	$236,000

3. Assume 11/12 of the DPH payments for a DY are made during the same fiscal year and the remaining 1/12 is paid in the subsequent fiscal year.

4. The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands) Demonstration Year	FY 2013-14 FF	FY 2014-15 FF
2012-13	$32,167	
2013-14	$285,083	$25,917
2014-15		$216,333
Total	**$317,250**	**$242,250**

Funding:

100% Health Care Support Fund (4260-601-7503)

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MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1085

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$248,602,000	$243,001,000
- STATE FUNDS	$124,301,000	$121,500,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$248,602,000	$243,001,000
STATE FUNDS	$124,301,000	$121,500,500
FEDERAL FUNDS	$124,301,000	$121,500,500

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1467 (Chapter 23, Statutes of 2012), W&I Code 14166.14

Interdependent Policy Changes:
PC 109 Hospital Stabilization
PC 111 Private Hospital Supplemental Fund Savings

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments, and 33.60% of the Stabilization funding for private hospitals as calculated by the formulas set forth in SB 1100 and SB 474 (Chapter 518, Statutes of 2007). This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

SB 1100 requires the transfer of $118,400,000 annually from the General Fund (GF) (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. The distribution of the Private Hospital Supplemental Fund will be based on

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 89

the requirements specified in SB 1100.

Reason for Change from Prior Estimate:
The changes are due to updated appropriation amounts, IGTs, interest, and program expenditures. GF savings from redirected stabilization funds and redirected American Recovery and Reinvestment Act of 2009 (ARRA) funds are now incorporated in this policy change and reflected in the net appropriation amounts.

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs.
2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.
3. IGTs are estimated to total $6,000,000 in FY 2013-14 and FY 2014-15, generating $3,000,000 in FFP each year.
4. Stabilization funding for private hospitals is calculated based on the interim reconciliation and won't be paid out until the interim payout process is developed.
5. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
6. SB 335 (Chapter 286, Statutes of 2011) reduces the Private Hospital Supplemental Fund by $17,500,000 in FY 2012-13 and $8,750,000 in FY 2013-14.
7. Under ARRA, California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The Private Hospital Supplemental Fund included funds received due to increased ARRA FMAP.
8. The Budget Act of 2013 redirected $23,000,000 ARRA funds from the Private Hospital Supplemental Fund to the GF as savings. The FY 2013-14 Appropriation was reduced by the redirected ARRA funds.
9. AB 1467 authorizes the redirection of stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the GF. The Budget Act of 2013 redirected $36,080,000 TF ($18,040,000 GF) from Private Hospital Supplemental payments to the GF as savings. The FY 2013-14 Appropriation was reduced by the redirected stabilization funds.
10. The FY 2013-14 Appropriation amount was reduced from $118,400,000 GF to $77,360,000 GF.
11. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.

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MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 89

It is assumed private hospital supplemental payments will be made on a cash basis as follows:

	TF	SF	FF
FY 2013-14			
FY 2012-13 Ending Balance	$104,982,000	$52,491,000	$52,491,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Redirect Stabilization Fund to GF	($36,080,000)	($18,040,000)	($18,040,000)
Redirect ARRA to GF	($46,000,000)	($23,000,000)	($23,000,000)
Net Appropriation	$154,720,000	$77,360,000	$77,360,000
Est. FY 2012-13 interest	$400,000	$200,000	$200,000
IGT	$6,000,000	$3,000,000	$3,000,000
Total	$266,102,000	$133,051,000	$133,051,000
Cash Expenditures to Hospitals	**$248,602,000**	**$124,301,000**	**$124,301,000**
SB 335 Reduction	$17,500,000	$8,750,000	$8,750,000
FY 2013-14 Ending Balance	$0	$0	$0
FY 2014-15			
FY 2013-14 Ending Balance	$0	$0	$0
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2013-14 interest	$201,000	$100,500	$100,500
IGT	$6,000,000	$3,000,000	$3,000,000
Total	$243,001,000	$121,500,500	$121,500,500
Cash Expenditures to Hospitals	**$243,001,000**	**$121,500,500**	**$121,500,500**
FY 2014-15 Ending Balance	$0	$0	$0

Funding:
100% GF (4260-105-0001)
Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
50% Private Hospital Supplemental Fund / 50%Title XIX FF (4260-601-3097/4260-101-0890)

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	11/2010
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1572

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$180,186,000	$0
- STATE FUNDS	$44,904,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$180,186,000	$0
STATE FUNDS	$44,904,000	$0
FEDERAL FUNDS	$135,282,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP, effective November 1, 2010 through December 31, 2013, consists of two components, the Medicaid Coverage Expansion (MCE) and the HCCI (CI). The MCE will cover eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI will cover those eligible individuals with family incomes above 133% through 200% of the FPL. Both are statewide county elective programs. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use two methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs)
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

The Department has used the CI cost claiming protocol for the MH/UCD as the basis for payments made on claims for dates of service from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and Conditions under the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 90

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. The CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013. The Department makes payments for dates of services beginning the second quarter of FY 2011-12 based on the new CPE cost claiming protocol.

The MCE program is not subject to a federal funding cap while HCCI funding is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13 and $180 million TC for DY 2013-14. Federal funding will be provided through the Health Care Support Fund (HCSF).

However, local spending under the HCCI has not reached $360 million. On June 28, 2013, the Department obtained CMS' approval of an amendment to the BTR Medicaid Demonstration waiver reallocating the unused HCCI funds for DY 2012-13 and DY 2013-14 to the SNCP uncompensated care component. The reallocation amounts are $97 million for DY 2012-13, and $26 million for DY 2013-14.

Reason for Change from Prior Estimate:
The changes are due to reallocation of unused HCCI funds to the SNCP uncompensated care components and revised payments due to CMS' approval of IGT-FQHC cost claiming protocol.

Methodology:
The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2013-14	TF	IGT-FQHC	FFP
DY6 - FY 2010-11	$3,463		$3,463
DY7 - FY 2011-12	$35,923	$17,962	$17,962
DY8 - FY 2012-13	$44,640	$17,962	$26,678
DY8 - FY 2012-13 (Rollover)	$48,500		$48,500
DY9 - FY 2013-14	$34,660	$8,981	$25,679
DY9 - FY 2013-14 (Rollover)	$13,000		$13,000
Total*	**$180,186**	**$44,904**	**$135,282**

Funding:
Health Care Support Fund (4260-601-7503)
Title XIX FFP (4260-101-0890)
LIHP IGT (4260-607-8502)

*Amounts may differ due to rounding.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1108

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$129,858,000	$119,676,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$129,858,000	$119,676,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$129,858,000	$119,676,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 95 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the CCS and GHPP from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the BTR allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The CCS and GHPP programs are included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 91

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

Methodology:

1. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF savings is reflected in the Family Health Estimate. The GF savings created will be used to support safety net hospitals under the MH/UCD and BTR.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change budgets those federal funds that are claimed using CPEs from the CCS and GHPP programs.

3. The Department will conduct the final reconciliations for Demonstration Year (DY) 2010-11 in FY 2013-14 and estimates that the Department will claim an additional $6.647 million in federal funds in FY 2013-14.

4. The final reconciliation for DY 2011-12 is anticipated to be completed in FY 2014-15. The Department estimates that it will have to repay the federal government $3.535 million in federal funds in FY 2014-15. The CCS and GHPP federal reimbursements are reduced by the final reconciliation amounts in this policy change.

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MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 91

The estimated CCS/GHPP federal reimbursements are:

(Dollars in Thousands)	CCS	GHPP	Total
FY 2005-06	$ 15,523	$ 8,485	$ 24,008
FY 2006-07	$ 46,856	$ 15,300	$ 62,156
FY 2007-08	$ 18,000	$ 8,000	$ 26,000
FY 2008-09	$ 20,958	$ 21,336	$ 42,294
FY 2009-10	$ 114,023	$ 41,073	$ 155,096
FY 2010-11	$ 59,959	$ 25,613	$ 85,572
FY 2011-12	$ 102,046	$ 55,019	$ 157,065
FY 2012-13	$ 67,718	$ 34,811	$ 102,529

(Dollars in Thousands) **FY 2013-14**	CCS FF	GHPP FF	Total
DSHP-BTR (DY 2013-14)	$ 78,773	$ 44,438	$ 123,211
DY 2010-11 Final Reconciliation	$ 4,366	$ 2,281	$ 6,647
Total	**$ 83,139**	**$ 46,719**	**$ 129,858**
FY 2014-15			
DSHP-BTR (DY 2014-15)	$ 78,773	$ 44,438	$ 123,211
DY 2011-12 Final Reconciliation	($ 7,368)	$ 3,833	($ 3,535)
Total	**$ 71,405**	**$ 48,271**	**$ 119,676**

Funding:
100% Health Care Support Fund (4260-601-7503)

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BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1672

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$110,000,000	$0
- STATE FUNDS	$55,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$110,000,000	$0
STATE FUNDS	$55,000,000	$0
FEDERAL FUNDS	$55,000,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Delivery System Reform Incentive Pool (DSRIP) Category 5 Human Immunodeficiency Virus (HIV) Transition Projects.

Authority:
SB 208 (Chapter 714, Statutes of 2010)
California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)
Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White)

Interdependent Policy Changes:
Not Applicable

Background:
As part of BTR, California counties implemented the Low Income Health Program (LIHP). The LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covers eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covers those with family incomes above 133% through 200% of the FPL.

The Department received program direction from the federal Health Resources and Services Administration (HRSA) and the Centers for Medicare & Medicaid Services (CMS) that according to the Ryan White HIV/AIDS Treatment Extension Act of 2009 “payer of last resort” requirements, Ryan White funded services can no longer be available to individuals living with HIV once they are determined eligible for and enrolled in a local LIHP. Therefore, these individuals who were previously covered under the Ryan White program will, upon enrollment in a local LIHP, be required to receive their medical care, pharmaceuticals, and mental health services under the LIHP.

The Department proposed an amendment to the Demonstration to CMS which authorizes the implementation of quality improvement projects within Designated Public Hospitals (DPHs). The DPHs support continuity of quality care, care coordination and other coverage transition issues concerning LIHP enrollees diagnosed with HIV, particularly those enrollees who previously received services under

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 92

the Ryan White program. CMS approved the amendment to the Demonstration on June 28, 2012.

The Department developed a DSRIP Category 5 HIV Transition Projects proposal (Proposal) which describes the framework, performance measures, deliverables, and incentive payment structure for DSRIP Category 5 HIV Transition Projects. This Proposal was submitted to CMS on July 20, 2012, and it was approved on October 31, 2012. The Proposal served as the foundation for the development of two new supplements to the Special Terms and Conditions (STC Attachment P – Supplement 1 and Attachment Q – Supplement 1) authorized by the June 28, 2012 amendment to the Demonstration. On November 7, 2012, the Department submitted the proposed new supplements to CMS and they were approved on November 19, 2012.

As of July 1, 2012, any DPH system with an approved DSRIP 5-year plan located within a county operating a LIHP and is a participating provider in that LIHP network may propose DSRIP Category 5 HIV Transition projects as a modification to its existing five year plan. Eleven DPHs elected to propose DSRIP plan modifications to incorporate Category 5 HIV Transition projects. Ten DSRIP plan modifications have been approved.

DPHs that elect to implement approved DSRIP Category 5 HIV Transition Projects will receive incentive payments under the Safety Net Care Pool (SNCP) upon achievement of project milestones. The DSRIP Category 5 HIV Transition Projects will be effective for 18 months from July 1, 2012 through December 31, 2013. The non-federal share of the payments will be through intergovernmental transfers (IGTs).

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

Methodology:

1. During the term of the LIHP component of the Demonstration commencing with FY 2012-13, a total of $110 million in DSRIP Category 5 HIV Transition Project payments (total computable) will be available annually.

2. $55 million (total computable) will be available for July 1 - December 31, 2013. The total available payments will be consistent with the Demonstration budget neutrality limit.

3. Total payment amounts will be allocated to each participating DPH on the basis of its approved proposal. Payment amounts will be disbursed in semi-annual payments, if project milestones are achieved.

(Dollars in Thousands) **FY 2013-14**	**TF**	**IGT**	**FFP**
2012-13	$55,000	$27,500	$27,500
2013-14	$55,000	$27,500	$27,500
Total	**$110,000**	**$55,000**	**$55,000**

Funding:
DSRIP IGT Fund (4260-601-3172)
Title XIX FFP (4260-101-0890)

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LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER:	93
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1622

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$0
- STATE FUNDS	$50,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$0
STATE FUNDS	$50,000,000	$0
FEDERAL FUNDS	$50,000,000	$0

DESCRIPTION

Purpose:
This policy change estimates the funding for the Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) Out-of-Network Emergency Care Services Fund that was created to reimburse out-of-network hospitals for providing certain services to LIHP MCE enrollees.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
SB 920 (Hernandez, Statutes of 2012)
California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
PC 158 Hospital QAF – Hospital Payments

Background:
SB 335 establishes the LIHP MCE Out-of-Network Emergency Care Services Fund, effective July 1, 2011 to December 31, 2013. Moneys shall be allocated from the fund by the Department to be matched with federal funds in accordance with the Special Terms and Conditions for the BTR. The Department shall disburse moneys from the fund to the LIHPs solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required post stabilization care provided by private hospitals that are outside the LIHP coverage network. SB 920 changes the amount transferred from the Hospital Quality Assurance Revenue Fund (HQARF) and subsequent payments. SB 920 further removes the non-designated public hospitals eligibility for this program.

Reason for Change from Prior Estimate:
The changes are due to implementation delay and non-availability of Hospital Quality Assurance Fee funds.

Methodology:
1. IGT funds are to be used in their entirety before HQARF funds are used.

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LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 93

2. SB 920 authorizes HQARF funds to be transferred to LIHP MCE Out-of-Network Emergency Care Services Fund.

3. Current trends with QAF collections and disbursements project that for FY 2013-14 and FY 2014-15, no QAF funds will be available for this program.

4. LIHPs will provide utilization data for FY 2011-12, and FY 2012-13 to the Department after the fiscal year and will provide FY 2013-14 data after the close of program period. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations. The program ends December 31, 2013.

5. The LIHP funds will be used to reimburse out-of-network hospitals.

6. IGTs will be deposited into and paid from the LIHP MCE Out-of-Network Emergency Care Services Fund.

(Dollars in Thousands)

FY 2013-14	TF	IGT*	LIHP	FFP**
2011-12	$40,000	$20,000	$0	$20,000
2012-13	$40,000	$20,000	$0	$20,000
2013-14	$20,000	$10,000	$0	$10,000
Total	**$100,000**	**$50,000**	$0	**$50,000**

Funding:
Reimbursement Fund (4260-610-0995)*
LIHP MCE OON Emergency Care Services Fund (4260-610-3201)
Title XIX FFP (4260-101-0890)**

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	5/2008
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1078

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$82,000,000	$82,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$82,000,000	$82,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$82,000,000	$82,000,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, pursuant to State Plan Amendment (SPA) 05-023, DPHs are to receive reimbursement based on certified public expenditures (CPEs) for their Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's physician and non-physician costs will be reconciled to the Medi-Cal cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

Reason for Change from Prior Estimate:
FY 2013-14 payments were adjusted to incorporate updated payment figures.

Methodology:
1. In FY 2013-14 and 2014-15, one annual payment will be made for DPHs.

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 94

2. Reconciliation/final settlement of the first program year 2005-06 is anticipated to be completed during FY 2013-14 upon conclusion of the Physician/Non-Physician Practitioner time studies that are a required component of the reconciliation process.

(Dollars in Thousands)	Estimated Expenditures	
FY 2013-14	**TF**	**FF**
DPH 2013-14	**$ 82,000**	**$ 82,000**
FY 2014-15		
DPH 2014-15	**$ 82,000**	**$ 82,000**

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

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BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER:	95
IMPLEMENTATION DATE:	11/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1571

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$66,339,000	$53,645,000
- STATE FUNDS	-$331,197,000	-$202,297,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$66,339,000	$53,645,000
STATE FUNDS	-$331,197,000	-$202,297,000
FEDERAL FUNDS	$397,536,000	$255,942,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
SB 208 (Chapter 71, Statutes 2009), Welfare & Institutions Code 14182.3
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
Interagency Agreement 10-87249 A 03
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 91 MH/UCD & BTR —CCS and GHPP
PC 105 MH/UCD & BTR —MIA-LTC
PC 106 MH/UCD & BTR —BCCTP

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 95

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Every Woman Counts (EWC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) · Song-Brown HealthCare Workforce Training · Steven M. Thompson Physician Corps Loan Repayment Program · Mental Health Loan Assumption Program University of California* California State University* California Community Colleges*
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

* CMS approval to include the University of California (UC), California State University (CSU) and California Community Colleges (CCCs) programs as DSHPs is still pending.

The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) for a five year total of $2 billion. In addition to the above programs, AB 1467 allows the DPHs to voluntarily provide excess CPEs as necessary for the State to claim the full $400 million.

Reason for Change from Prior Estimate:
The change is due to:

- Updated program expenditures,
- Claiming for UC, CSU, and CCCs are anticipated in FY 2014-15 because of a delay in CMS approval on the claiming protocols. Accrual years prior to DY 2014-15 for these programs are no longer in the estimate.
- FY 2013-14 claims for County Mental Health Services Program and Reserved SNCP Funds for DSHP include totals from prior accrual years.

Methodology:

1. The FFP for other departments is offset against State General Fund expenses in Item 4260-101-0001. In FY 2013-14, of the $66,339,000 ADAP FFP available, $66,339,000 is offset against the CDPH budget. In FY 2014-15, of the $53,645,000 ADAP FFP available, $53,645,000 is offset against the CDPH budget.

2. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR —MIA-LTC and MH/UCD & BTR —BCCTP policy changes. The additional FFP received for

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 95

MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR —CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

3. In prior years, the CPEs available from DSHP programs have not been sufficient to claim the $400 million FFP for each DY. AB 1467 permits the State to use DPH CPEs, as a condition for DPHs receiving Health Care Coverage Initiative rollover payments, to claim up to the $400 million limit. See "Reserved SNCP Funds for DSHP" in the table below.

4. Pursuant to the BTR, DSHP claiming for CMSP was effective for dates of services from November 1, 2010 to December 31, 2011. Claiming for CMSP was completed in FY 2012-13.

The estimated BTR DSHP federal reimbursements are as follows:

(Dollars In Thousands)	**Total DSHP (Accrual Basis)**		**Included in this PC (Cash Basis)**	
	FFP DY 2013-14	FFP DY 2014-15	**FFP FY 2013-14**	**FFP FY 2014-15**
CCS	$78,773	$78,773		
GHPP	$44,438	$44,438		
MIA-LTC	$18,932	$18,932		
BCCTP	$1,915	$1,915		
DHCS Total	$144,058	$144,058		
ADAP	$66,339	$53,645	$66,339	$53,645
Co. Mental Health	$42,281	$44,142	$67,033	$44,142
DDS	$63,714	$63,714	$63,714	$63,714
EWC	$0	$5,796	$0	$5,796
PCTP	$1,295	$1,295	$1,295	$1,295
OSHPD	$12,747	$12,747	$12,747	$12,747
Univ. of Calif.	$0	$2,575	$0	$2,575
CSU/Comm. Colleges	$0	$29,362	$0	$29,362
CMSP	$0	$0	$0	$0
Reserved SNCP funds for DSHP	$69,566	$42,666	$186,408	$42,666
Total Other Programs	$255,942	$255,942	$397,536	$255,942
Grand Total	$400,000	$400,000	**$397,536**	**$255,942**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

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BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1576

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$56,473,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$56,473,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$56,473,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Low Income Health Program (LIHP) payments for California Department of Corrections and Rehabilitation (CDCR) inmates receiving hospital inpatient services at hospitals off the grounds of the correctional facilities.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 92 (Chapter 36, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The BTR established the LIHP effective November 1, 2010 through December 31, 2013. AB 1628 and SB 92 authorize the Department to claim federal funding for inpatient hospital services for certain inmates of CDCR correctional facilities. The eligible inpatient hospital services are services provided at hospitals that are off the grounds of the correctional facilities for inmates with family incomes at or below 133% of the Federal Poverty Level determined. The Department determines the eligible inmates for either the Medi-Cal program or the LIHP operated by the counties.

See Medi-Cal Inpatient Hospital Costs for CDCR Inmates policy change for the Medi-Cal covered costs.

CDCR/California Correctional Health Care Services (CCHCS) will forward applications to the Department for the purpose of determining LIHP eligibility. CDCR/CCHCS will pay the hospitals under contract for covered inpatient services. CDCR/CCHCS will provide paid claims data to the individual county programs for certification and attestation of the Certified Public Expenditures (CPEs) and allowable inpatient hospital services for reimbursement of federal funding at the usual FMAP.

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BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 96

Reason for Change from Prior Estimate:
The changes are due to updated inpatient costs, eligible inmates and delay in contract execution between local LIHPs and CDCR.

Methodology:

1. CDCR/CCHCS began to submit LIHP claims in March 2012.

2. The Department processes LIHP applications and assumes no additional county administrative costs.

3. 18 LIHPs will submit claims through FY 2013-14.
   - 19 LIHPs were implemented by March 2013.
   - One LIHP was implemented with an enrollment cap through December 31, 2013, and no claims will be submitted.
   - For two LIHPs, the date of services began on July 1, 2011.
   - For the remaining 16 LIHPs, the dates of services began on October 1, 2011.

4. Assume 326 average monthly approved LIHP inpatient stays.

   - Assume the Department will process 380 applications per month of which 74% will be LIHP inmate applications.
   - Assume 96% of processed LIHP inmate applications will be approved.
   - Assume there are 270 average monthly eligible LIHP inmates.
     380 total inmate applications processed x 74% LIHP x 96% approval rate = 270
   - Assume 20.8% of eligible LIHP inmates will receive two inpatient hospital services during a month.
     270 approved application x 20.8% = 56 additional monthly inpatient stays
   - 270 LIHP approved inmate applications + 56 additional monthly stays = 326

5. Assume 18 average monthly approved inpatient stays for each LIHP.
   - 326 total average monthly inpatient stays ÷ 18 LIHPs = 18

6. The annual LIHP inmate inpatient service costs are $71,217,960 TF.
   - The average cost per inpatient stay is estimated to be $18,205
   - 326 monthly approved inpatient stays x $18,205 average cost x 12 months = $71,217,960 TF

7. For FY 2011-12, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $55,051,920.

   - Effective July 1, 2011: 2 LIHPs x 18 approved applications x $18,205 average cost x 12 months = $7,864,560
   - Effective October 1, 2011: 16 LIHPs x 18 approved applications x $18,205 average cost x 9 months = $47,187,360

8. For FY 2012-13, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $71,217,960.

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BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 96

9. For FY 2013-14, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $35,608,980.

10. The estimated federal fund for LIHP inmate inpatient service costs on an accrual basis:

(Dollars In Thousands)

	TF	FF	CPE
FY 2011-12	$27,526	$27,526	$27,526
FY 2012-13	$35,609	$35,609	$35,609
FY 2013-14	$17,804	$17,804	$17,804

11. The Centers for Medicare and Medicaid Services (CMS) approved the claiming protocols in August 2012.

- The Department began processing payments for FY 2011-12 and FY 2012-13 in FY 2012-13.
- Remaining payments for FY 2011-12 and FY 2012-13 will be paid in FY 2013-14.
- All payments for FY 2013-14 will be paid in FY 2013-14.

The estimated payments for inmate inpatient services on a cash basis:

(Dollars In Thousands)

FY 2013-14	TF	FF	CPE
FY 2011-12	$13,814	$13,814	$13,814
FY 2012-13	$24,854	$24,854	$24,854
FY 2013-14	$17,804	$17,804	$17,804
Total**	**$56,473**	**$56,473**	**$56,473**

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

*Not included in Total Fund
**Amounts may differ due to rounding

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MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER:	97
IMPLEMENTATION DATE:	7/2009
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1162

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$83,834,000	$126,000,000
- STATE FUNDS	$41,917,000	$63,000,000
PAYMENT LAG	0.5820	0.8595
% REFLECTED IN BASE	8.73 %	5.81 %
APPLIED TO BASE		
TOTAL FUNDS	$44,531,900	$102,004,900
STATE FUNDS	$22,265,950	$51,002,470
FEDERAL FUNDS	$22,265,950	$51,002,470

DESCRIPTION

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 107 MH/UCD & BTR — DPH Interim Rate

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the Selective Provider Contracting Program (SPCP) negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Reason for Change from Prior Estimate:
Based on expenditures through August 2013, DPH users and utilization-per-user were lower than previously projected for the period from March 2013 to August 2013. As a result, actual DPH payments in FY 2012-13 and the first two months of FY 2013-14 were also lower than previously projected. The decrease in FY 2013-14 in this estimate is due to adjusted base trends to account for the updated expenditure data.

In addition, because the FY 2012-13 interim rates were fully implemented in FY 2012-13, this estimate no longer assumes an Erroneous Payment Correction (EPC) in FY 2013-14.

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MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 97

Methodology:

1. The DPHs received new FY 2013-14 interim rates as of July 1, 2013. These rates were based on FY 2011-12 costs trended to FY 2013-14.

2. Assume an average increase of 10% in FY 2013-14 interim rates.

3. Assume a 4.4% increase in the FY 2014-15 interim rates.

4. An additional cost of $83,834,000 Total Fund (TF) is estimated for FY 2013-14. The lagged cost on a cash basis is estimated to be approximately $44,530,000 TF.

5. An additional cost of $126,000,000 TF is estimated for FY 2014-15. The lagged cost on a cash basis is estimated to be approximately $102,007,000 TF.

6. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/50% FFP and are budgeted as 50% GF/50% FFP. The full adjustment is shown in the MH/UCD & BTR—DPH Interim Rate policy change.

Funding:

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

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	7/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1698

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$30,750,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$30,750,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$30,750,000	$0

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of allocating unspent Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP) for Designated Public Hospitals (DPHs).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) are used to obtain the federal financial participation (FFP) for the LIHP-HCCI. Federal funding for the program is capped at $360 million total computable annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14. However, local spending under the HCCI has not reached $360 million. The Department has obtained approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent HCCI money to the SNCP uncompensated care component. See the BTR—Health Care Coverage Initiative Rollover Funds policy change for more information.

The funding reallocated to the SNCP will be shared 50/50 between the state and DPHs to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy change BTR—Increase Designated State Health Programs (DSHPs) for more information.

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BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 98

Reason for Change from Prior Estimate:
The Department received federal approval to claim DY 8 (2012-13) and DY 9 (2013-14) rollover amounts in FY 2013-14. DY 2012-13 amounts were updated and DY 2013-14 amounts have been added to the estimate.

Methodology:

1. The LIHP-HCCI total computable annual limit is $360 million for DYs 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14.

2. The Department projects LIHP-HCCI expenditures will be $184 million in DY 2010-11, $214 million in DY 2011-12, $263 million in DY 2012-13, and $154 million in DY 2013-14.

3. At a Federal Medical Assistance Percentage (FMAP) of 50%, $88 million FFP is available to rollover from DY 2010-11, $73 million FFP is available to rollover from DY 2011-12, $48.5 million FFP will be available to rollover from DY 2012-13, and $13 million FFP is available to rollover from DY 2013-14.

4. In FY 2013-14, assume the Department will rollover available funding from DY 2012-13 and DY 2013-14 for a total of $61.5 million FFP.

5. Assume funds will be split 50/50 between the State and DPHs.

6. DPHs will receive $30.75 million in additional funding for uncompensated care costs in FY 2013-14.

(Dollars in Millions) **FY 2013-14**	**FF**	**GF**
HCCI Rollover		
DY 2012-13	($48.50)	$0.00
DY 2013-14	($13.00)	$0.00
Total	($61.50)	$0.00
Amount to SNCP-DPHs	**$30.75**	**$0.00**
Amount to SNCP-DSHPs	$30.75	($30.75)

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1153

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$13,988,000	$7,595,000
- STATE FUNDS	$13,988,000	$7,595,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$13,988,000	$7,595,000
STATE FUNDS	$13,988,000	$7,595,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.75
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration
AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:
Not Applicable

Background:
Stabilization funding is calculated as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between:
  a. The NDPHs' aggregate payment increase, and
  b. The sum of $0.544 million and 0.64% of total stabilization funding.

- Private Hospitals will receive total funds payment equal to the difference between:
  a. The Private Hospitals' aggregate payment increase, and
  b. The sum of $42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.

- Distressed Hospitals will receive total funds payments equal to the lesser of $23.5 million or 10% of total stabilization funding, with a minimum of $15.3 million.

- DPHs will receive General Fund (GF) payments to the extent that the state-funded programs certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 99

Reason for Change from Prior Estimate:
Final reconciliations for Demonstration Years (DY) 2005-06 and 2006-07 for DPHs are anticipated to be completed in FY 2013-14 and FY 2014-15, respectively. The estimate is changed to show updated stabilization payments for DPHs for DY 2005-06 in FY 2013-14 and DY 2006-07 in FY 2014-15. DY 2007-08 through 2009-10 stabilization payments for DPHs and Distressed Hospitals are now estimated to be paid after FY 2014-15 and are no longer in the estimate.

Methodology:

1. Stabilization funding is calculated after the final reconciliation of the DPH interim payments is completed.

2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.

3. Stabilization funding to NDPHs, Private Hospitals, and Distressed Hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.

4. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Stabilization Funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the new BTR.

5. Pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. FY 2013-14 GF savings are budgeted in the MH/UCD & BTR—Private Hospital Supplemental Payment and MH/UCD & BTR—NDPH Supplemental Payment policy changes.

6. A total of $36,080,000 TF ($18,040,000 GF) private hospital stabilization funding was transferred to the Private Hospital Supplemental Fund. This amount was redirected to the GF in FY 2013-14 resulting in a reduced FY 2013-14 Appropriation. See the MH/UCD & BTR—Private Hospital Supplemental Payment policy change for more information.

7. A total of $538,000 TF ($269,000 GF) NDPH stabilization funding was transferred to the NDPH Supplemental Fund. This amount was redirected to the GF in FY 2013-14 resulting in a reduced FY 2013-14 Appropriation. See the MH/UCD & BTR—NDPH Supplemental Payment policy change for more information.

8. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.

9. Final reconciliations will result in updated stabilization amounts for NDPH and Private Hospitals. These updated stabilization amounts will not be paid out.

10. Distressed Hospital payments are calculated as part of the MH/UCD waiver final reconciliation. These payments were previously distributed based on negotiations with the Office of the Selective Provider Contracting Program, formerly CMAC. The Department will now distribute these payments. Distressed Hospital payments for 2005-06 and 2006-07 were paid prior to FY 2013-14.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 99

11. Stabilization funding is not a component of the BTR waiver. Stabilization payments will end once the DY 2009-10 final reconciliation is complete.

The estimated stabilization payments are:

(Dollars in Thousands)		
FY 2013-14		
2005-06	**TF**	**GF**
DPHs	**$13,988**	**$13,988**
FY 2014-15		
2006-07		
DPHs	**$7,595**	**$7,595**

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

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	10/2007
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1152

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,877,000	$108,328,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,877,000	$108,328,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$11,877,000	$108,328,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.4
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of MH/UCD and BTR, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 or 2552-10 cost report for the respective fiscal year ending. Payments resulting from the Interim Reconciliation will be funded with federal funds. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, and Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports, which is expected to occur within three years of the submission of the cost report.

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 100

Reason for Change from Prior Estimate:
The change is due to the delayed and updated final reconciliation amount for Fiscal Year (FY) 2005-06 and delays to the final reconciliations for FY 2006-07, FY 2007-08, and FY 2008-09. The final reconciliation for FY 2006-07 will be delayed to FY 2014-15. The final reconciliations for FY 2007-08 and FY 2008-09 will be delayed to FY 2015-16 and FY 2016-17, respectively. FY 2007-08 and FY 2008-09 will no longer be included in this estimate.

Methodology:

1. DPHs' interim reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the filed Medi-Cal 2552-96 or 2552-10 cost report costs and their respective payments.

2. DPH's final reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the audited Medi-Cal 2552-96 or 2552-10 cost report costs and the respective payments.

3. The final reconciliation for 2005-06 is expected to be completed by September 2013. The final payout is $11,876,903.

4. The final reconciliation for 2006-07 is expected to be completed by May 2015 and is estimated to be $108,328,000. There are no plans to issue a tentative settlement for 2006-07.

(Dollars in Thousands)

	FF
FY 2013-14	
2005-06 Final Reconciliation	**$11,877**
FY 2014-15	
2006-07 Final Reconciliation	**$108,328**

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

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UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER:	101
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1769

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$10,193,000	$536,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,193,000	$536,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$10,193,000	$536,000

DESCRIPTION

Purpose:
This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) approved a waiver amendment to make uncompensated care payments through the Safety Net Care Pool (SNCP) – Uncompensated Care to IHS facilities.

Covered Services for Uninsured Individuals
IHS facilities may receive uncompensated care payments for the provision of California Medicaid State Plan primary care services and optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009) to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who are not enrolled in a Low Income Health Program (LIHP) or Medi-Cal, and
- have no source of third party coverage for the services they receive under this demonstration.

Covered Services for Medi-Cal Enrollees
For Medi-Cal enrolled individuals, IHS facilities may receive uncompensated care payments for the provision of optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5.

FFP Claiming Methodology
Claims for allowable services will be paid at the IHS encounter rate. Claiming for Federal Financial Participation (FFP) will be based on certified public expenditures under this demonstration. For

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

Optional services eliminated from the State Plan include:

- Acupuncture
- Audiology
- Chiropractic
- Dental
- Incontinence creams and washes
- Optician/optical lab
- Podiatry
- Psychology
- Speech therapy

Reason for Change from Prior Estimate:
Updated data resulted in a decreased number of IHS eligible uninsured individuals meeting the criteria for the uncompensated care payments. Additionally, payments are now scheduled to occur in FY 2013-14 and FY 2014-15.

Methodology:

1. Assume 29,000 patients annually are served by the tribal health programs.

2. Assume there are no non-IHS eligibles paid at the FMAP rate.

3. Assume 15% of the 29,000 patients meet the criteria for the uncompensated care payments for tribal health programs.

4. Assume IHS facilities provide uncompensated care services to 4,350 IHS eligible uninsured individuals annually.

   29,000 patients annually x 15% = 4,350 IHS eligible uninsured individuals

5. Assume the annual average number of encounters per individual is 3.

6. The IHS global encounter rate is $330.

7. For uninsured individuals, the estimated total annual uncompensated care payment is $4,306,500 FF.

   4,350 individuals x 3 encounters x $330 = $4,306,500 FF

8. Assume IHS facilities lost $10,000,000 FF annually from the requirement under ABX3 5 that excludes specified optional benefits from coverage under the Medi-Cal program. It is expected that IHS facilities will claim $10,000,000 FF annually for optional benefit services under this program.

9. To IHS facilities, the estimated total annual uncompensated care payment is $14,306,500 FF.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

$4,306,500 + $10,000,000 = $14,306,500 FF Annually

10. Pursuant to the Special Terms and Conditions (STCs), the program is effective for 9 months from April 5, 2013 through December 31, 2013.

    $14,306,500 / 12 months x 9 months = $10,729,875 FF

11. Assume 95% of payments are to be made in FY 2013-14 with 5% of payments expected to be made in FY 2014-15 due to delays in claiming by IHS tribal health facilities.

12. Payments made in FY 2013-14 are estimated to be:

    FY 2013-14: $10,729,875 x 95% = $10,193,000 FF (Rounded)

13. Payments made in FY 2014-15 are estimated to be:

    FY 2014-15: $10,729,875 x 5% = $536,000 FF (Rounded)

	TF	FF
FY 2013-14	**$10,193,000**	**$10,193,000**
FY 2014-15	**$536,000**	**$536,000**

Funding:
100% Health Care Support Fund (4260-601-7503)

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MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER:	102
IMPLEMENTATION DATE:	9/2007
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1154

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$9,613,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,613,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,613,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD).

Authority:
SB 1448 (Chapter 76, Statutes of 2006)
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds is available annually under the Safety Net Care Pool (SNCP) to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10. The funding for the HCCI is linked to the SNCP requirements reflected in the MH/UCD-Safety Net Care Pool policy change.

The federal funds available will reimburse the HCCI counties at an amount equal to the applicable Federal Medical Assistance Percentage of their Certified Public Expenditures (CPEs) for health care services provided to eligible low-income uninsured persons. The HCCI counties will submit their CPEs to the Department for verification and submission for federal financial participation (FFP).

The Demonstration, which would have ended on August 31, 2010, was extended until October 31, 2010. The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) became effective November 1, 2010. The federal funds for the extension period (September and October 2010) are provided through the new BTR funding for the first year of the BTR ending June 30, 2011. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 102

In FY 2013-14, reallocation of unspent funds and related reconciliation of payments will occur for DY 2008-09 and DY 2009-10. The payment reconciliations may result in additional FFP payments to or recovery of FFP payments from affected counties.

Reason for Change from Prior Estimate:
The changes are due to DY 2009-10 reconciliation payments shifting from FY 2012-13 to FY 2013-14. For DY 2007-08 reconciliation claims, payments were expected to be made in FY 2013-14, however due to new data updates, this reconciliation will not happen.

Methodology:
1. Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	$ 8,204
Contra Costa County/Contra Costa Health Services	$ 15,250
County of Orange	$ 16,872
County of San Diego, Health and Human Services Agency	$ 13,040
County of Kern, Kern Medical Center	$ 10,000
Los Angeles County Department of Health Services	$ 54,000
San Francisco Department of Public Health	$ 24,370
San Mateo County	$ 7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	$ 20,700
Ventura County Health Care Agency	$ 10,000
Total	$180,000

2. Payments due to reallocation and related reconciliation for DY 2008-09 and DY 2009-10 under the MH/UCD HCCI are expected to be paid in FY 2013-14.

The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2013-14	**TF**	**FFP**	**CPE***
2008-09	$4,509	$4,509	$4,509
2009-10	$5,104	$5,104	$5,104
Total**	**$9,613**	**$9,613**	$9,613

*Not included in TF.
**Amounts may differ due to rounding.

Funding:
Health Care Support Fund (4260-601-7503)

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MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1076

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,510,000	$3,802,000
- STATE FUNDS	$4,255,000	$1,901,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,510,000	$3,802,000
STATE FUNDS	$4,255,000	$1,901,000
FEDERAL FUNDS	$4,255,000	$1,901,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.17
Medi-Cal Hospital/Uninsured Care Section 1115(a) Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 109 Hospital Stabilization

Background:
As part of the MH/UCD and the BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers).

AB 1467 (Chapter 23, Statutes of 2012) changed the NDPH reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. The Department submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), which was later withdrawn by the Department. NDPHs will continue to receive supplemental payments.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 103

Reason for Change from Prior Estimate:
The change is due to updated appropriation amounts and program expenditures. FY 2012-13 NDPH supplemental payments did not occur therefore increasing the amount of available funds for FY 2013-14. GF savings from redirected stabilization funds are now incorporated in this policy change and reflected in the net appropriation amounts.

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated.

2. SB 1100 requires that $1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.

3. The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010.

4. In FY 2013-14 a two-year total of $3,800,000 was to be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.

5. AB 1467 authorizes the redirection of the stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the GF. The Budget Act of 2013 redirected $538,000 TF ($269,000 GF) from NDPH supplemental payments to the GF as savings. As a result, the FY 2013-14 Appropriation amount was reduced to $3,531,000.

6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission under section 14165(b) of the W&I Code.

It is assumed NDPH supplemental payments will be made on a cash basis as follows:

FY 2013-14	**TF**	**SF**	**FF**
FY 2012-13 Ending Balance	$1,444,000	$722,000	$722,000
Appropriation (GF)	$7,600,000	$3,800,000	$3,800,000
Redirect Stabilization Fund to GF	($538,000)	($269,000)	($269,000)
Net Appropriation (GF)	$7,062,000	$3,531,000	$3,531,000
Est. FY 2012-13 Interest Earned	$4,000	$2,000	$2,000
Total Funds Available	$8,510,000	$4,255,000	$4,255,000
Cash Expenditures in FY 2013-14	**$8,510,000**	**$4,255,000**	**$4,255,000**
FY 2013-14 Ending Balance	$0	$0	$0
FY 2014-15			
FY 2013-14 Ending Balance	$0	$0	$0
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
Est. FY 2013-14 Interest Earned	$2,000	$1,000	$1,000
Total Funds Available	$3,802,000	$1,901,000	$1,901,000
Cash Expenditures in FY 2014-15	**$3,802,000**	**$1,901,000**	**$1,901,000**
FY 2014-15 Ending Balance	$0	$0	$0

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MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 103

Funding:
100% GF (4260-104-0001)
NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
50% NDPH Supplemental Fund / 50% Title XIX FF (4260-601-3096/4260-101-0890)

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	104
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1072

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,949,000	$35,917,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,949,000	$35,917,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,949,000	$35,917,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.7
MH/UCD

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a SNCP was established to support the provision of services to the uninsured. The SNCP makes available $586 million in federal funds each of the five Demonstration Years (DYs) for baseline and stabilization funding and an additional $180 million per DY for implementing a healthcare coverage initiative during the last three years of the MH/UCD (Health Care Coverage Initiative). The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program (BCCTP). SNCP funding for the Health Care Coverage Initiative and for state-only programs are included in other policy changes.

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual $100,000,000 of the SNCP federal financial participation (FFP) for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs.

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 104

CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs and SLAMSP, and drawn down by the state-funded programs cannot exceed $586 million.

The MH/UCD was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the new BTR demonstration. A modified SNCP continues in the new demonstration; see policy change Bridge to Reform – Safety Net Care Pool.

Reason for Change from Prior Estimate:
The change is due to the delay of the final reconciliations for DY 2005-06 through DY 2009-10. It is anticipated that the final reconciliation for DY 2005-06 will now occur in FY 2013-14 and DY 2006-07 final reconciliation will now occur in FY 2014-15. The final reconciliations for DY 2007-08 through DY 2009-10 are delayed as well and will no longer be included in this estimate.

Methodology:
The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands)

Demonstration Year	State-Only Funded Programs	Due to DPHs and SLAMSP
2005-06	$83,151	$502,849
2006-07	$54,800	$531,200
2007-08	$76,190	$509,810
2008-09	$54,450	$531,550
2009-10	$86,910	$499,090

The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)

Demonstration Year	FY 2013-14 FF	FY 2014-15 FF
2005-06	$1,949	
2006-07		$35,917
Total	**$1,949**	**$35,917**

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1079

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$19,327,000	-$20,118,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$19,327,000	-$20,118,000
FEDERAL FUNDS	$19,327,000	$20,118,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the Medically Indigent Adult Long-Term Care (MIA-LTC) program claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 95 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the MIA-LTC from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The MIA-LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The MIA-LTC program is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 105

Methodology:

1. The FFP received for the MIA-LTC program will be deposited in the Health Care Support Fund, Item 4260-601-7503.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the MIA-LTC programs.

3. The Department will conduct the final reconciliation for Demonstration Year (DY) 2010-11 in FY 2013-14 and estimates to claim an additional $395,000 in federal funds in FY 2013-14.

4. The final reconciliation for DY 2011-12 is anticipated to be completed in FY 2014-15. The Department estimates to claim an additional $1,186,000 in federal funds in FY 2014-15.

The MIA-LTC federal reimbursements are:

	FF
FY 2005-06	$12,834,000
FY 2006-07	$7,328,000
FY 2007-08	$14,743,000
FY 2008-09	$23,160,000
FY 2009-10	$28,147,000
FY 2010-11	$11,386,000
FY 2011-12	$33,737,000
FY 2012-13	$19,661,000
FY 2013-14	
DSHP-BTR (DY 2013-14)	$18,932,000
DY 2010-11 Final Reconciliation	$395,000
Total	**$19,327,000**
FY 2014-15	
DSHP-BTR (DY 2014-15)	$18,932,000
DY 2011-12 Final Reconciliation	$1,186,000
Total	**$20,118,000**

Funding:

100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

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MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER:	106
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1084

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,786,000	-$2,179,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,786,000	-$2,179,000
FEDERAL FUNDS	$1,786,000	$2,179,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the State-Only Breast and Cervical Cancer Treatment Program (BCCTP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 95 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established by the MH/UCD.

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the BCCTP, effective January 1, 2002, for women under 200% of the federal poverty level (FPL). A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Beneficiaries are screened through Centers for Disease Control (CDC) and Family Planning, Access, Care, and Treatment (Family PACT) providers.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The BCCTP is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 106

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

Methodology:

1. The FFP received for the BCCTP will be deposited in the Health Care Support Fund, Item 4260-601-7503.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the BCCTP program.

3. The Department will conduct the final reconciliation for Demonstration Year (DY) 2010-11 in FY 2013-14 and estimates having to repay the federal government $129,000 in FY 2013-14. The BCCTP federal reimbursements are reduced by the final reconciliation amounts in this policy change.

4. The final reconciliation for DY 2011-12 is anticipated to be completed in FY 2014-15. The Department estimates claiming an additional $264,000 in federal funds in FY 2014-15.

The BCCTP federal reimbursements are:

	FF
FY 2005-06	$591,000
FY 2006-07	$291,000
FY 2007-08	$ 0
FY 2008-09	$1,211,000
FY 2009-10	$2,137,000
FY 2010-11	$1,095,000
FY 2011-12	$2,439,000
FY 2012-13	$1,158,000
FY 2013-14	
DSHP-BTR (DY 2013-14)	$1,915,000
DY 2010-11 Final Reconciliation	($129,000)
Total	**$1,786,000**
FY 2014-15	
DSHP-BTR (DY 2014-15)	$1,915,000
DY 2011-12 Final Reconciliation	$264,000
Total	**$2,179,000**

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 106

Funding:
100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

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MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	107
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1161

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$441,435,000	-$491,392,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$441,435,000	-$491,392,000
FEDERAL FUNDS	$441,435,000	$491,392,000

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from 50% federal financial participation (FFP) to 100% FFP to reimburse Designated Public Hospitals (DPHs).

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 97 MH/UCD & BTR — DPH Interim Rate Growth

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs no longer receive the negotiated per diem rates under the Selective Provider Contracting Program (SPCP) for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Instead, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The previous SPCP negotiated per diem rates were paid with 50% FFP and 50% GF. Typically, the items in the Medi-Cal Estimate base trend are paid with 50% FFP and 50% GF. Since the DPH interim rate is paid with 100% FFP, an adjustment to shift from 50% GF to 100% FFP must be made in the base estimate data.

Reason for Change from Prior Estimate:
Based on expenditures through August 2013, DPH users and utilization-per-user were lower than previously projected for the period from March 2013 to August 2013. As a result, actual DPH payments in FY 2012-13 and the first two months of FY 2013-14 were also lower than previously projected. The decrease in FY 2013-14 in this estimate is due to adjusted base trends to account for the updated expenditure data.

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MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 107

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)	Expenditures	GF to FF shift
FY 2013-14	**$882,870**	**$441,435**
FY 2014-15	**$982,784**	**$491,392**

Funding:

50% GF / 50% Title XIX FF (4260-101-001/0890)
100% Title XIX FF (4260-101-0890)

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BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER:	108
IMPLEMENTATION DATE:	7/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1697

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$30,750,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$30,750,000	$0
FEDERAL FUNDS	$30,750,000	$0

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of allocating unspent Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP) for the Designated State Health Programs (DSHPs).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) are used to obtain the federal financial participation (FFP) for the LIHP-HCCI. Federal funding for the program is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14. However, local spending under the HCCI has not reached $360 million. The Department has obtained approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent HCCI money to the SNCP uncompensated care component. See the BTR—Health Care Coverage Initiative Rollover Funds policy change for more information.

The funding reallocated to the SNCP will be shared 50/50 between the state and Designated Public Hospitals (DPHs) to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy change BTR—Increase Safety Net Care Pool for more information.

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BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 108

Reason for Change from Prior Estimate:
The Department received federal approval to claim DY 8 (2012-13) and DY 9 (2013-14) rollover amounts in FY 2013-14. DY 2012-13 amounts were updated and DY 2013-14 amounts have been added to the estimate.

Methodology:

1. The LIHP-HCCI total computable annual limit is $360 million for DYs 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14.

2. The Department projects LIHP-HCCI expenditures will be $184 million in DY 2010-11, $214 million in DY 2011-12, $263 million in DY 2012-13, and $154 million in DY 2013-14.

3. At a Federal Medical Assistance Percentage (FMAP) of 50%, $88 million FFP is available to rollover from DY 2010-11, $73 million FFP is available to rollover from DY 2011-12, $48.5 million FFP will be available to rollover from DY 2012-13, and $13 million FFP is available to rollover from DY 2013-14.

4. In FY 2013-14, assume the Department will rollover available funding from DY 2012-13 and DY 2013-14 for a total of $61.5 million FFP.

5. Assume funds will be split 50/50 between the state and DPHs.

6. General Fund savings of $30.75 million is expected in FY 2013-14.

(Dollars in Millions) **FY 2013-14**	**FF**	**GF**
HCCI Rollover		
DY 2012-13	($48.50)	$0.00
DY 2013-14	($13.00)	$0.00
Total	($61.50)	$0.00
Amount to SNCP-DPHs	$30.75	$0.00
Amount to SNCP-DSHPs	**$30.75**	**($30.75)**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

HOSPITAL STABILIZATION

REGULAR POLICY CHANGE NUMBER:	109
IMPLEMENTATION DATE:	7/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1644

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the General Fund (GF) savings from redirecting private and non-designated public hospitals (NDPH) stabilization funding that has not yet been paid.

Authority:
AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:
PC 89 MH/UCD & BTR—Private Hospital Supplemental Payment
PC 103 MH/UCD & BTR—NDPH Supplemental Payment

Background:
AB 1467 allows the Department to redirect stabilization funding that has not been paid for fiscal year (FY) 2005-06 through FY 2009-10 for private hospitals and NDPHs. The stabilization funding was estimated to be paid in FY 2012-13 and FY 2013-14. A portion of the GF savings achieved was used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 and FY 2006-07.

SB 1100 (Chapter 560, Statutes of 2005) established a methodology for distributing the federal funding made available under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD). Under SB 1100, additional funding termed “stabilization funding” may be available to designated public hospitals (DPHs), NDPH, private DSH, and distressed hospitals for each of the five years (FY 2005-06 through FY 2009-10) of the MH/UCD.

The methodology for determining the stabilization funding to each hospital group and the portion of the stabilization funding distributed by the Department are described in the MH/UCD-Stabilization Funding policy change.

Reason for Change from Prior Estimate:
The redirected private and NDPH stabilization savings are incorporated into the MH/UCD & BTR—Private Hospital Supplemental Payment and MH/UCD & BTR—NDPH Supplemental Payment policy changes.

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HOSPITAL STABILIZATION

REGULAR POLICY CHANGE NUMBER: 109

Methodology:
Not Applicable

Funding:
Not Applicable

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	7/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1459

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$20,762,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$20,762,000	$0
FEDERAL FUNDS	$20,762,000	$0

DESCRIPTION

Purpose:
This policy change estimates the savings from the federal flexibilities policies which allows the claiming of unused Safety Net Care Pool (SNCP) federal funds to offset State General Fund expenditures.

Authority:
Welfare & Institutions Code 14166.221
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, $360 million of the funding was unused. On February 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

Methodology:
1. The Department may claim these funds using the certified public expenditures from Designated Public Hospitals, the Coverage Initiative Program, and State-Only funded programs, including Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).

2. AB 1653 (Chapter 218, Statutes of 2010) allows the State to retain up to $420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 110

flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. $135.083 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

The General Fund savings resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
CMHS	$0	($28,925)	$28,925
Final Reconciliation (EAPC & ADAP)	$0	$8,163	($8,163)
Total	**$0**	**($20,762)**	**$20,762**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

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PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS

REGULAR POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1786

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the savings from redirecting American Recovery and Reinvestment Act of 2009 (ARRA) funds from the Private Hospital Supplemental Fund to the General Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 89 MH/UCD & BTR — Private Hospital Supplemental Payment

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

SB 1100 requires the transfer of $118,400,000 annually from the General Fund (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. The distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100. See the MH/UCD & BTR—Private Hospital Supplemental Payment policy change for more information.

Under ARRA, California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The Private Hospital Supplemental Fund included funds received due to increased ARRA FMAP.

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PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS

REGULAR POLICY CHANGE NUMBER: 111

Reason for Change from Prior Estimate:
The redirected ARRA savings is incorporated into the MH/UCD & BTR — Private Hospital Supplemental Payment policy change.

Methodology:
Not Applicable

Funding:
Not Applicable

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BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1694

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$61,500,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$61,500,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$61,500,000	$0

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of allocating unspent Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP). These funding streams are available pursuant to the California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 90 BTR—Low Income Health Program - HCCI
PC 98 BTR—Increase Safety Net Care Pool
PC 108 BTR—Increase Designated State Health Programs

Background:
The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) are used to obtain the federal financial participation (FFP) for the LIHP-HCCI. Federal funding for the program is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14. However, local spending under the HCCI has not reached $360 million. The Department has obtained approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent HCCI money to the SNCP uncompensated care component.

The funding reallocated to the SNCP will be shared 50/50 between the state and Designated Public Hospitals (DPHs) to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy changes BTR-Increase Safety Net Care Pool and BTR-Increase Designated State Health Programs

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 112

(DSHPs) for more information.

Reason for Change from Prior Estimate:
The Department received federal approval to claim DY 8 (2012-13) and DY 9 (2013-14) rollover amounts in FY 2013-14. DY 2012-13 amounts were updated and DY 2013-14 amounts have been added to the estimate.

Methodology:

1. The LIHP-HCCI total computable annual limit is $360 million for DYs 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14.

2. The Department projects LIHP-HCCI expenditures will be $184 million in DY 2010-11, $214 million in DY 2011-12, $263 million in DY 2012-13, and $154 million in DY 2013-14.

3. At a Federal Medical Assistance Percentage (FMAP) of 50%, $88 million FFP is available to rollover from DY 2010-11, $73 million FFP is available to rollover from DY 2011-12, $48.5 million FFP will be available to rollover from DY 2012-13, and $13 million FFP is available to rollover from DY 2013-14.

4. In FY 2013-14, assume the Department will rollover available funding from DY 2012-13 and DY 2013-14 for a total of $61.5 million FFP.

5. Assume funds will be split 50/50 between the State and DPHs.

(Dollars in Millions) **FY 2013-14**	**FF**	**GF**
HCCI Rollover		
DY 2012-13	($48.50)	$0.00
DY 2013-14	($13.00)	$0.00
Total	**($61.50)**	**$0.00**
Amount to SNCP-DPHs	$30.75	$0.00
Amount to SNCP-DSHPs	$30.75	($30.75)

Funding:
100% Health Care Support Fund (4260-601-7503)

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DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER:	113
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1708

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$105,552,000	-$237,633,000
- STATE FUNDS	-$52,776,000	-$118,816,500
PAYMENT LAG	0.7380	0.8594
% REFLECTED IN BASE	8.56 %	3.78 %
APPLIED TO BASE		
TOTAL FUNDS	-$71,229,400	-$196,502,200
STATE FUNDS	-$35,614,680	-$98,251,110
FEDERAL FUNDS	-$35,614,680	-$98,251,110

DESCRIPTION

Purpose:
This policy change estimates savings that will occur by implementing the Diagnosis Related Group (DRG) payment methodology for Medi-Cal inpatient services for private hospitals and Non-Designated Public Hospitals (NDPHs) and freezing rates at the July 1, 2013 level.

Authority:
SB 853 (Chapter 717, Statutes 2010), Welfare & Institutions Code 14105.28

Interdependent Policy Changes:
Not Applicable

Background:
Currently, NDPHs receive reimbursement for Medi-Cal fee-for-service (FFS) acute inpatient services according to the negotiated per-diem rates under the Selective Provider Contracting Program (SPCP). Contract hospitals bill for some services carved-out of the per-diem charges separately. For non-contract hospitals, Medi-Cal reimburses FFS inpatient services with cost-based interim per-diem rates.

Under the current payment system, these hospitals bill Medi-Cal the daily inpatient service charges on a per day usage. Providers receive payment for the actual number of days a beneficiary remains in their care, and not on a diagnosis or treatment strategy basis.

On July 1, 2013, the Department transitioned private hospitals to a DRG payment system which correlates reimbursement to the Medi-Cal beneficiary's assigned DRG. DRG reimbursement is designed to treat all patients assigned to a specific DRG as having a similar clinical condition requiring similar interventions.

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 113

AB 1467 (Chapter 23, Statutes of 2012) changed the NDPH reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. The Department submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), which was later withdrawn by the Department. NDPHs will continue to receive payments under the current methodology through December 31, 2013. These hospitals will transition to a DRG payment system on January 1, 2014.

In Medi-Cal managed care counties, the Department contracts with health plans to provide services, including inpatient services, to Medi-Cal beneficiaries enrolled in the plans. Each plan receives a per member per month capitation rate for enrolled beneficiaries. The DRG payment system froze base rates at the July 1, 2013 level which directly impacts managed care capitation rates.

Reason for Change from Prior Estimate:
The change is due to updated payment data and the inclusion of NDPH savings. In addition, managed care savings are no longer in the estimate because they are now included in the managed care capitation rates.

Methodology:

1. The DRG payment methodology was implemented on July 1, 2013 for private hospitals.

2. Assume the DRG payment methodology will be implemented on January 1, 2014 for NDPHs.

3. Using 2009 trended data, adjusted to reflect the Senior and Persons with Disabilities (SPD) transition into managed care, and assuming stable utilization and patient case mix and projected rate increases;
    - FY 2013-14 expenditures under the prior methodology are estimated to be $3,217,878,000 TF for private hospitals and $171,541,000 TF for NDPHs.

    - FY 2014-15 expenditures under the prior methodology are estimated to be $3,340,673,000 TF for private hospitals and $178,087,000 TF for NDPHs.

4. FY 2013-14 and FY 2014-15 FFS payments under the DRG payment system are frozen at the July 1, 2013 level and are estimated to be $3,115,067,000 TF for private hospitals and $166,060,000 TF for NDPHs.

5. NDPH FFS savings in FY 2013-14 are for 6 months, due to the implementation date of January 1, 2014, and are estimated to be:

    ($171,541,000 /12 x 6 months) – ($166,060,000 /12 x 6 months) = $2,740,500 TF ($1,370,250 GF)

6. Private hospital savings in FY 2013-14 are estimated to be:

    $3,217,878,000 - $3,115,067,000 = $102,811,000 TF ($51,405,500 GF)

7. Private hospital and NDPH FFS savings in FY 2014-15 are estimated to be:
    - $3,340,673,000 - $3,115,067,000 = $225,606,000 TF ($112,803,000 GF) for private hospitals
    - $178,087,000 - $160,060,000 = $12,027,000 TF ($6,013,500 GF) for NDPHs

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 113

The DRG savings are as follows:

(Dollars in Thousands)	TF	GF	FF
FY 2013-14 Annual			
Private FFS	($102,811)	($51,406)	($51,405)
NDPH FFS	($2,741)	($1,371)	($1,370)
Total savings	**($105,552)**	**($52,777)**	**($52,775)**

(Dollars in Thousands)	TF	GF	FF
FY 2014-15 Annual			
Private FFS	($225,606)	($112,803)	($112,803)
NDPH FFS	($12,027)	($6,014)	($6,013)
Total savings	**($237,633)**	**($118,817)**	**($118,816)**

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

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MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER:	117
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1781

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$783,819,000	$1,252,660,000
- STATE FUNDS	$345,594,000	$516,786,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$783,819,000	$1,252,660,000
STATE FUNDS	$345,594,000	$516,786,500
FEDERAL FUNDS	$438,225,000	$735,873,500

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by Managed Care Organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 140 MCO Tax Managed Care Plans

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The tax is effective July 1, 2013, through June 30, 2016.

Reason for Change from Prior Estimate:
Updated rates for FY 2013-14 and new rates for FY 2015-16.

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

2. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 117

3. The premium revenue was multiplied by the MCO tax amount of 3.9375% to determine total tax revenue.

4. Capitation rate increases due to the MCO tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from Fund 3156 on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd Care Plans–Funding Adjustment policy change.

5. The impact of rate increases related to the ACA Optional and Mandatory Expansions are included in these numbers.

The costs of capitation rate increases related to the imposition of the MCO tax are expected to be:

(In Thousands)	MCO Tax	FFP	TF
FY 2013-14	**$345,594**	**$438,225**	**$783,819**
FY 2014-15	**$516,786**	**$735,874**	**$1,252,660**

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

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1054

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$744,394,000	$820,130,000
- STATE FUNDS	$355,300,000	$391,449,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$744,394,000	$820,130,000
STATE FUNDS	$355,300,000	$391,449,000
FEDERAL FUNDS	$389,094,000	$428,681,000

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14163 and 14164

Interdependent Policy Changes:
PC 135 Managed Care IGT Admin. And Processing Fee
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 Mgd. Care Plans

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

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

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

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

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 118

2010. The IGT will continue on an ongoing basis.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; Merced and Sonoma Counties were effective retroactive to October 1, 2009; and Orange, Napa, and Yolo counties were effective retroactive to July 1, 2010. The IGTs for Marin, Mendocino, and Ventura Counties were effective retroactive to July 1, 2011. The IGTs will continue on an ongoing basis.

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

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

The IGTs for Fresno, Stanislaus, and Tulare Counties are expected to be effective retroactive to October 1, 2011. Once approved by Centers for Medicare and Medicaid Services (CMS), it is anticipated the IGTs will continue on an ongoing basis.

Geographic Managed Care:
The IGTs for Sacramento and San Diego Counties are expected to be effective retroactive to January 1, 2012. Once approved by CMS, it is anticipated the IGTs will continue on an ongoing basis.

AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax (MCO Tax) of 2.35% 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 (Chapter 33, Statutes of 2013) extended the gross premium tax through June 30, 2013. SB 78 also provides for a 3.9375% statewide sale tax on the total operating revenue of Medi-Cal Managed Care plans effective July 1, 2013, through June 30, 2016.

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

(Dollars in Thousands)

FY 2013-14

	IGT*	Regular FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	**$355,300**	**$338,672**	**$25,800**	**$24,622**	**$389,094**	**$744,394**

FY 2014-15

	IGT*	Regular FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	**$391,449**	**$373,129**	**$28,425**	**$27,127**	**$428,681**	**$820,130**

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MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 118

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
Reimbursement (4260-610-0995)*

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TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1766

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$125,278,000	$5,706,904,000
- STATE FUNDS	$61,273,500	$2,804,982,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$125,278,000	$5,706,904,000
STATE FUNDS	$61,273,500	$2,804,982,500
FEDERAL FUNDS	$64,004,500	$2,901,921,500

DESCRIPTION

Purpose:
This policy changes estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioning from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
PC 123 Transfer of IHSS Costs to CDSS
PC 143 Transition of Dual Eligibles-Long Term Care
PC 197 Transfer of IHSS Costs to DHCS
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:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. By enrolling these eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

The CCI will mandatorily enroll dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services.

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TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 119

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Reason for Change from Prior Estimate:
The implementation date changed from January 2014 to April 2014. Additionally, the phase-in schedule has been revised.

Methodology:

1. Assume Dual Eligibles in the Medicare fee-for-service (FFS) program populations receiving LTC institutional and community-based services under the traditional Fee-for-Service (FFS) model will begin enrolling into the CCI on April 1, 2014. Medicare FFS beneficiaries from San Mateo County will phase-in over 3 months. Medicare FFS beneficiaries from the other seven counties will phase-in over 12 months. Dual Eligibles in Alameda and Santa Clara will be enrolling in the demonstration starting in July 2014.

2. Beneficiaries enrolled in a Medicare Advantage plan will have their Medi-Cal benefits transition from FFS to managed care beginning in July 2014. Medicare Advantage beneficiaries from San Mateo County will phase-in over 3 months. Medicare FFS beneficiaries from the other seven counties will phase-in over 12 months.

3. In January 2015, Medicare Advantage eligibles will enroll in the CCI. All remaining Medicare Advantage eligibles that have not yet phased-in from Medi-Cal FFS to Medi-Cal managed care will transition in January 2015.

4. Medi-Cal only eligibles and those receiving only partial Medicare coverage will have their LTC and community-based services included in Medi-Cal managed care beginning in July 2014. This phase-in over 12 months.

5. Assume there are an estimated 1,019,000 beneficiaries in April 2014 who will be phased into a managed care plan in the eight pilot counties. 381,000 of these beneficiaries are dual eligibles who will be enrolled into the demonstration.

6. Assume for participating dual eligibles, there will an overall average 1.15% savings in FY 2013-14 in FY 2014-15.

7. Estimated below is the overall impact of the Dual and LTC Integration proposal in FY 2013-14 and FY 2014-15.

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TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 119

(Dollars in Thousands)

FY 2013-14	TF	GF	FFP	Reimbursment
Managed Care Payments (PC 119):				
Non HCBS	$72,206	$36,103	$36,103	$0
HCBS	$53,221	$25,245	$27,976	$0
Existing Managed Care Duals	($149)	($75)	($74)	$0
Total	**$125,278**	**$61,273**	**$64,005**	**$0**
FFS Savings (PC 143):				
Non HCBS	($50,440)	($25,220)	($25,220)	$0
HCBS	($164)	($82)	($82)	$0
Defer Mgd. Care Payment	($90,107)	($45,054)	($45,053)	$0
Total	($140,711)	($70,356)	($70,355)	$0
IHSS FFS Savings (In the Base)	($21,973)	$0	($21,973)	$0
Delay 1 Checkwrite (In the Base)	$6,326	$3,163	$3,163	$0
Transfer of IHSS Costs to DHCS (PC 197)	$0	($21,973)	$0	$21,973
Transfer of IHSS Costs to CDSS (PC 123)	$45,505	$0	$0	$45,505
Other Administration Costs (OA 19)	$8,786	$2,543	$6,243	$0
Total of CCI PCs including pass through	$23,211	($25,350)	($18,917)	$67,478

(Dollars in Thousands)

FY 2014-15	TF	GF	FFP	Reimbursement
Managed Care Payments (PC 119):				
Non HCBS	$3,811,408	$1,905,704	$1,905,704	$0
HCBS	$1,898,211	$900,636	$997,575	$0
Existing Managed Care Duals	($2,715)	($1,358)	($1,357)	$0
Total	**$5,706,904**	**$2,804,982**	**$2,901,922**	**$0**
FFS Savings (PC 143):				
Non HCBS	($3,152,713)	($1,576,357)	($1,576,356)	$0
HCBS	($11,556)	($5,778)	($5,778)	$0
Defer Mgd. Care Payment	($624,574)	($312,287)	($312,287)	$0
Total	($3,788,843)	($1,894,422)	($1,894,421)	$0
IHSS FFS Savings (In the Base)	($782,780)	$0	($782,780)	$0
Delay 1 Checkwrite (In the Base)	$85,162	$42,581	$42,581	$0
Transfer of IHSS Costs to DHCS (PC 197)	$0	($782,780)	$0	$782,780
Transfer of IHSS Costs to CDSS (PC 113)	$1,615,660	$0	$0	$1,615,660
Other Administration Costs (OA 19)	$8,070	$2,543	$5,527	$0
Total of CCI PCs including pass through	$2,844,173	$172,905	$272,829	$2,398,440

Funding:

50% Title XIX FFP / 50% GF (4260-101-0890/0001)
100% Title XIX FFP (4260-101-0890)

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER:	120
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1588

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$443,548,000	$399,710,000
- STATE FUNDS	$221,774,000	$199,855,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$443,548,000	$399,710,000
STATE FUNDS	$221,774,000	$199,855,000
FEDERAL FUNDS	$221,774,000	$199,855,000

DESCRIPTION

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

Authority:
SB 208 (Chapter 714, Statutes of 2010)

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 135 Managed Care IGT Admin. & Processing Fee
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:
Effective June 1, 2011, SPDs who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Since 2005, the inpatient care for fee-for-service (FFS) members receiving services at a DPH facility has been reimbursed under a cost-based payment and financing structure. The DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided. It is important to note that as a result of this funding arrangement, the State was not providing the state\local match requirement. Instead, the CPE process satisfied the state\local match requirement. Due to this payment structure, the transition of FFS Seniors and Persons with Disabilities (SPDs) to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 120

levels comparable to FFS, while at the same time ensuring that there are not new State GF expenditures. Other, non-inpatient services provided within the FFS structure by a DPH or its affiliated governmental entities (collectively, Public Providers) were being reimbursed through a combination of regulatory FFS rates, for which the nonfederal share was supported with State GF, and supplemental reimbursement above the FFS fee schedule, financed through the CPE mechanism, for the otherwise unreimbursed allowable costs of the services. The services for which these FFS supplemental reimbursement mechanisms apply include hospital outpatient, physician and non-physician practitioner professional, and non-hospital clinic services but does not include federally qualified health center (FQHC) services. These FFS payment structures no longer occur with respect to SPD beneficiaries that have transitioned to the managed care payment environment. Therefore, appropriate rate and other funding adjustments needed to be developed to reflect the historical patient reimbursement provided by these FFS methodologies in order to ensure access to services and adequate funding to these critical safety net providers.

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs. This portion is budgeted in the PC “General Fund Reimbursements from DPHs.” In addition, the Public Providers will provide the non-federal share of the adjusted capitation related to the full recognition of the allowable costs (previously addressed by the FFS state plan reimbursement methodologies) for outpatient and other non-inpatient services through an IGT which is budgeted in this policy change.

Reason for Change from Prior Estimate:
Final methodologies and amounts have now been determined as well which Public Providers are affected.

Methodology:
Inpatient Hospital Services

1. Determine the baseline of DPH inpatient services/costs that are subject to transition into managed care.
2. Account for managed care factors applied in the capitation rate development process.
3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization which yields the calculated historical DPH allowable cost per day and related utilization.
4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rates for transitioned members.
5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members’ baseline capitation rates. This portion is budgeted in the PC “General Fund Reimbursements from DPHs as stated above.
6. Calculate capitation rate adjustments.
7. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient rate adjustments.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 120

Non-Inpatient Services

1. Determine the baseline of Public Provider non-inpatient services/costs in FFS that are subject to transition into managed care and for which supplemental payments are available for Public Providers to draw down under FFS (excluding FQHC services).
2. Account for managed care factors applied in the capitation rate development process.
3. Calculate the expected Public Providers' non-inpatient cost per services for applicable SPDs for each applicable category of services.
4. Calculate the Public Provider utilization and costs that have already been built into the baseline managed care capitation rate for transitioning SPD members for the applicable categories of services.
5. Calculate the capitation rate adjustments for each applicable category of service.
6. Calculate the amount of funding (IGT) needed from Public Providers for the state/local match related to the non-inpatient rate adjustments.

Total Inpatient Hospital and Non-Inpatient Services

1. Add IGTs for Inpatient hospital services and non-inpatient services to determine total IGTs from DPHs.
2. The initial (Year 1) IGTs include the period of July 1, 2011, through December 31, 2012, for the GMC model counties and July 1, 2011, through September 30, 2012 for the Two-Plan model counties. IGTs in the amount of $195,932,000 were received from the DPHs in FY 2012-13. Subsequent Two-Plan amended IGTs in the amount of $21,919,000 for Year 1 are expected to be paid by the DPHs in FY 2013-14.
3. The Year 2 IGTs include the period of January 1, 2013, thorough December 21, 2013, for the GMC model counties, and October 1, 2012, through September 30, 2013, for the Two-Plan model counties. The estimated IGTs in the amount of $199,855,000 are expected to be paid by the DPHs in FY 2013-14.
4. The Year 3 IGTs include the period January 1, 2014, through December 31, 2014, for the GMC model counties, and October 31, 2013, through September 30, 2014, for the Two-Plan model counties. The estimated IGTs have not yet been determined; therefore, a placeholder in the amount of $199,855,000 is estimated for FY 2014-15.

(In Thousands)	IGT	FFP	TF
FY 2013-14			
Year 1 (amended)	$21,919	$21,919	$43,838
Year 2	$199,855	$199,855	$399,710
Total	**$221,774**	**$221,774**	**$443,548**
FY 2014-15	**$199,855**	**$199,855**	**$399,710**

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

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EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1652

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$383,441,000	$0
- STATE FUNDS	$191,720,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$383,441,000	$0
STATE FUNDS	$191,720,500	$0
FEDERAL FUNDS	$191,720,500	$0

DESCRIPTION

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

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 137 Extend Gross Premium Tax – Funding Adjustment
PC 134 Extend Gross Premium Tax

Background:
SB 78 was signed by the Governor on June 27, 2013, and extended the gross premium tax through June 30, 2013, on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. Due to a delay in approval, the FY 2012-13 payments are not expected to be paid until FY 2013-14.

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

Methodology:
1. The gross premium tax proceeds are required to be used to increase the capitation rates due to the payments made to the State that result directly from the imposition of the gross premium tax.

2. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

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EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 121

3. 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 (Fund 3156) on a quarterly basis. The reimbursement is budgeted in the Extend Gross Premium Tax – Funding Adjustment policy change.

The costs of capitation rate increases related to the extension of the gross premium tax sunset date are expected to be:

(Dollars in Thousands)	**Gross Premium Tax**	**FFP**	**TF**
FY 2013-14	$191,720	$191,721	**$338,441**

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

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TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1653

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$45,505,000	$1,615,660,000
- STATE FUNDS	$45,505,000	$1,615,660,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,505,000	$1,615,660,000
STATE FUNDS	$45,505,000	$1,615,660,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to the California Department of Social Services (CDSS) for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles who receive LTC institutional services, IHSS, and other Home and Community-Based Services (HCBS) to managed care health plans beginning April 1, 2014.

The IHSS program provides an alternative to out-of-home care, such as nursing homes or board and care facilities. The transition and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS. It is assumed that the transition to managed care will increase the use of IHSS and other HCBS by 3.5%.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the CDSS pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population.

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TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 123

This policy change addresses the transfer of IHSS costs from the managed care rates to the Department who will in turn transfer the funds to CDSS to pay the IHSS providers. The policy change, Transfer of IHSS Costs to DHCS, reflects the transfer of General Fund and county funds to the Department which is used to increase managed care capitation rates.

Reason for Change from Prior Estimate:
The implementation date changed from January 2014 to April 2014. Additionally, the phase-in schedule has been revised.

Methodology:
1. Estimated below is the overall impact of the Dual and LTC Integration proposal in FY 2013-14 and FY 2014-15.

(Dollars in Thousands) **FY 2013-14**	**TF**	**GF**	**FFP**	**Reimbursement**
Managed Care Payments (PC 119):				
Non HCBS	$72,206	$36,103	$36,103	$0
HCBS	$53,221	$25,245	$27,976	$0
Existing Managed Care Duals	($149)	($75)	($74)	$0
Total	$125,278	$61,273	$64,005	$0
FFS Savings (PC 143):				
Non HCBS	($50,440)	($25,220)	($25,220)	$0
HCBS	($164)	($82)	($82)	$0
Defer Mgd. Care Payment	($90,107)	($45,054)	($45,053)	$0
Total	($140,711)	($70,356)	($70,355)	$0
IHSS FFS Savings (In the Base)	($21,973)	$0	($21,973)	$0
Delay 1 Checkwrite (In the Base)	$6,326	$3,163	$3,163	$0
Transfer of IHSS Costs to DHCS (PC 197)	$0	($21,973)	$0	$21,973
Transfer of IHSS Costs to CDSS (PC 123)	**$45,505**	**$0**	**$0**	**$45,505**
Other Administration Costs (OA 19)	$8,786	$2,543	$6,243	$0
Total of CCI PCs including pass through	$23,211	($25,350)	($18,917)	$67,478

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TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 123

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
Managed Care Payments (PC 119):				
Non HCBS	$3,811,408	$1,905,704	$1,905,704	$0
HCBS	$1,898,211	$900,636	$997,575	$0
Existing Managed Care Duals	($2,715)	($1,358)	($1,357)	$0
Total	$5,706,904	$2,804,982	$2,901,922	$0
FFS Savings (PC 143):				
Non HCBS	($3,152,713)	($1,576,357)	($1,576,356)	$0
HCBS	($11,556)	($5,778)	($5,778)	$0
Defer Mgd. Care Payment	($624,574)	($312,287)	($312,287)	$0
Total	($3,788,843)	($1,894,422)	($1,894,421)	$0
IHSS FFS Savings (In the Base)	($782,780)	$0	($782,780)	$0
Delay 1 Checkwrite (In the Base)	$85,162	$42,581	$42,581	$0
Transfer of IHSS Costs to DHCS (PC 197)	$0	($782,780)	$0	$782,780
Transfer of IHSS Costs to CDSS (PC 123)	**$1,615,660**	**$0**	**$0**	**$1,615,660**
Other Administration Costs (OA 19)	$8,070	$2,543	$5,527	$0
Total of CCI PCs including pass through	$2,844,173	$172,905	$272,829	$2,398,440

Funding:
100% Reimbursement (4260-610-0995)

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RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	10/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1788

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$338,810,000	$0
- STATE FUNDS	$169,405,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$338,810,000	$0
STATE FUNDS	$169,405,000	$0
FEDERAL FUNDS	$169,405,000	$0

DESCRIPTION

Purpose:
This policy change estimates managed care capitation rate increases.

Authority:
Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:
PC 114 Two Plan Model
PC 115 County Organized Health Systems
PC 116 Geographic Managed Care
PC 159 Extend Gross Premium Tax – Incr. Capitation Rates
PC 121 Extend Gross Premium Tax – Funding Adjustment
PC 137 Extend Gross Premium Tax

Background:
Retroactive rate adjustments are due to the rate redeterminations for the Rate Year 2012-13 for Two Plan, COHS, and GMC, and additional amounts for Fiscal Year 2011-12 for Two Plan and GMC models. Capitation rate increases will be paid in FY 2013-14.

Reason for Change from Prior Estimate:
The 2012-13 rates for Ventura County (Gold Coast Health Plan), Two Plan, and GMC were calculated in 2013-14. Further analysis of available data has resulted in an additional rate determination of the Seniors and Persons with Disabilities (SPD) rate category for the Two Plan and GMC Models for the 2011-12 and 2012-13 rate periods.

Methodology:

1. The Department determined the difference between what was calculated to be paid for FY 2012-13 and what was actually paid for FY 2012-13. This difference will be paid in FY 2013-14.

2. A comparison between rates paid for SPDs in 2011-12 and 2012-13 rate periods and newly redetermined rates was used to determine the additional amounts that should be paid to plans

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 124

in FY 2013-14.

(Dollars in Thousands)

FY 2013-14	2011-12 Retro Rate Adjustments	2012-13 Retro Rate Adjustments	TF	GF	FF
Two Plan	$93,634	$208,718	$302,352	$151,176	$151,176
COHS	$0	$10,724	$10,724	$5,362	$5,362
GMC	$13,118	$12,616	$25,734	$12,867	$12,867
Total	$106,752	$232,058	**$338,810**	**$169,405**	**$169,405**

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

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	9/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1651

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$21,097,000	-$16,426,000
- STATE FUNDS	$10,548,500	-$8,213,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,097,000	-$16,426,000
STATE FUNDS	$10,548,500	-$8,213,000
FEDERAL FUNDS	$10,548,500	-$8,213,000

DESCRIPTION

Purpose:
This policy change estimates the savings related to expanding managed care into rural counties that are now fee-for-service (FFS) only.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)

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:
Managed care is currently in 30 counties. AB 1467 expands managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

This expansion is being implemented using four models, County Organized Health Systems (COHS), Regional, San Benito, and Imperial.

Reason for Change from Prior Estimate:
The implementation date changed from June to September 2013 for the COHS model. The implementation date changed from June to November 2013 for the Regional, San Benito, and Imperial models.

Methodology:
1. The expansion occurred on September 1, 2013 for the COHS model, which includes the 8 northern counties of Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. All beneficiaries were required to enroll.

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 127

2. The expansion occurred on November 1, 2013, for the Regional model, which includes the 18 counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. SPD beneficiaries in all Regional counties have the option to enroll in managed care between implementation and April 30, 2014, and it was assumed 15% would enroll. After April 30, 2014, all non-dual SPDs will be required to enroll. Dual SPDs will retain the option to enroll, and it is assumed that 15% would remain enrolled. All other beneficiaries in the Regional counties were mandatorily enrolled on the implementation date.

3. The expansion occurred on November 1, 2013, for the Imperial model. SPD beneficiaries in Imperial county have the option to enroll in managed care between implementation and April 30, 2014, and it was assumed 15% would enroll. After April 30, 2014, all non-dual SPDs will be mandatorily enrolled, with the ability to opt out. Dual SPDs will retain the option to enroll, and it is assumed that 15% would remain enrolled. All other beneficiaries in Imperial county were mandatorily enrolled on the implementation date.

4. The expansion occurred on November 1, 2013, for the San Benito model. SPD beneficiaries in San Benito county have the option to enroll in managed care between implementation and April 30, 2014, and it was assumed 15% would enroll. After April 30, 2014, all non-dual SPDs will be mandatorily enrolled, with the ability to opt out. Dual SPDs will retain the option to enroll, and it was assumed that 15% would remain enrolled. All other beneficiaries in San Benito County were enrolled on the implementation date, but had the ability to opt out. It is assumed 45% would opt out.

5. Assume that costs for the COHS expansion will be 96% of current FFS costs.

6. Assume that costs for the other expansions will be 99% of current FFS costs.

7. The expansion of managed care will result in a cost in FY 2013-14 on a cash basis because capitation payments begin immediately, while FFS payments continue for services provided before the expansion due to the time it takes providers to bill for services. The costs for FY 2013-14 and savings for FY 2014-15 are expected to be:

FY 2013-14	
Managed Care Capitation Payments	$612,209,000
Managed Care Deferral	($106,505,000)
FFS Savings	($629,932,000)
FFS Payment Lag	.7693
FFS Lagged Savings	($484,607,000)
FY 2013-14 Cost	**$21,097,000**
FY 2014-15	
Managed Care Capitation Payments	$831,627,000
Managed Care Deferral	($682,000)
FFS Savings	($854,377,000
FFS Payment Lag	.9918
FFS Lagged Savings	($847,371,000)
FY 2014-15 Savings	**($16,426,000)**

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

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INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER:	128
IMPLEMENTATION DATE:	11/2009
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1455

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,862,000	$0
- STATE FUNDS	$4,358,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,862,000	$0
STATE FUNDS	$4,358,000	$0
FEDERAL FUNDS	$4,504,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by the Gross Premium Tax proceeds for the service periods ending June 30, 2012. These funds will be used for the non-federal share of capitation rate increases.

Authority:
AB 1422 (Chapter 157, Statutes of 2009)
SB 853 (Chapter 717, Statutes of 2010)
ABX1 21 (Chapter 11, Statutes of 2011)
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 118 Managed Care Rate Range IGTs
PC 133 Funding Adjustment of Gross Premium Tax to GF

Background:
AB 1422 imposed a Gross Premium Tax (GPT) on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue does not include amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The GPT imposed by AB 1422 was effective retroactively to January 1, 2009 through December 31, 2010. SB 853 extended the GPT through June 30, 2011. ABX1 21 extended the GPT through June 30, 2012. SB 78 extended the GPT through July 1, 2013; however the GPT for this extension period is budgeted in PC 207. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period will be matched with federal funds at the level in effect at that time.

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INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 128

The Managed Care Intergovernmental Transfer provides for capitation rate increases to the managed care plans. Because a portion of the IGTs from prior periods won't occur until FY 2013-14, the GPT applies to these payments and will be reflected in FY 2013-14 costs.

Reason for Change from Previous Estimate:
The GPT dollars come from the FY 2011-12 Ventura IGT, the FY 2011-12 GMC IGT, and the FY 2011-12 Two-Plan IGT which are being paid in FY 2013-14. Changes are due to the additional GMC IGT for the FY 2011-12 period. The GPT for the 2012-13 IGTs are budgeted in PC 207.

Methodology:

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

2. Capitation rate increases due to the GPT are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the GPT fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to GF policy change.

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

4. FY 2013-14 amounts are one-time retroactive rate adjustments using FY 2011-12 GPTs on IGTs.

Funding:

	2013-14
Gross Premium Tax (Item 4260-601-3156)	$4,358,000
FF (Title XIX) (Item 4260-101-0890)	$4,188,000
FF (Title XXI) (Item 4260-113-0890)	$316,000
Total	**$8,862,000**

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NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	7/1998
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	95

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$2,000,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,000,000	$2,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

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

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

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

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CAPITATED RATE ADJUSTMENT FOR FY 2014-15

REGULAR POLICY CHANGE NUMBER:	132
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1338

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$465,411,000
- STATE FUNDS	$0	$231,818,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$465,411,000
STATE FUNDS	$0	$231,818,200
FEDERAL FUNDS	$0	$233,592,800

DESCRIPTION

Purpose:
The policy change estimates the increase for the Managed Care capitation rate for fiscal year (FY) 2013-14.

Authority:
Not Applicable

Interdependent Policy Changes:
PC 114 Two Plan Model
PC 115 County Organized Health Systems
PC 116 Geographic Managed Care
PC 129 AIDS Healthcare Centers (Other M/C)
PC 130 Family Mosaic Capitated Case Mgmt. (Other M/C)
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:
Managed care capitation rates will be rebased in FY 2014-15 as determined by the rate methodology based on more recent data. Adjustments will be implemented based on the rate year of the managed care model types.

This policy change budgets a placeholder increase of 3.63% for the FY 2014-15 rates based on the FY 2011-12 to FY 2012-13 overall rate increase. The managed care rate adjustments for FY 2014-15 will be available for the May 2014 Estimate.

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CAPITATED RATE ADJUSTMENT FOR FY 2014-15

REGULAR POLICY CHANGE NUMBER: 132

(Rounded)	Cost by Plan	Rate Adjustment	Rate Increase
COHS	$3,607,617,000	3.63%	**$130,956,000**
Two Plan	$7,847,249,000	3.63%	**$284,855,000**
GMC	$1,357,157,000	3.63%	**$49,265,000**
AHF	$9,263,000	3.63%	**$336,000**
Total	$12,821,286,000	3.63%	**$465,412,000**

Reason for Change from Prior Estimate:
This is a new policy change.

Funding:

(In Thousands)	COHS	Two Plan	GMC	AHF	Total
Title XIX 50/50 FFP 4260-101-0001/0890	$130,173	$281,815	$48,846	$336	$461,170
State GF 4260-101-0001	$87	$715	$97	$0	$899
Family Planning 90/10 GF 4260-101-0001/0890	$695	$2,325	$322	$0	$3,342
Total FFP	$65,712	$143,000	$24,713	$168	**$233,593**
Total GF	$65,243	$141,855	$24,552	$168	**$231,818**
Total	**$130,955**	**$284,855**	**$49,265**	**$336**	**$465,411**

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	2/2011
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1586

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

Authority:
AB 1422 (Chapter 157, Statutes of 2009)
SB 853 (Chapter 717, Statutes of 2010)
ABX1 21 (Chapter 11, Statutes of 2011)
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 128 Increase in Capitation Rates for Gross Premium Tax
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:
AB 1422 imposed a Gross Premium Tax (GPT) on the total operating revenue of Medi-Cal Managed Care plans. The proceeds from the tax are used to offset the capitation rates. The FY 2011-12 impact of the increase in capitation payments related to the GPT is included in the Increase in Capitation Rates for Gross Premium Tax policy change.

The GPT imposed by AB 1422 was effective retroactively to January 1, 2009, through December 31, 2010. SB 853 extended the GPT through June 30, 2011. ABX1 21 extended the GPT through June 30, 2012. SB 78 extended the GPT through July 1, 2013; however, the GPT for this extension period is budgeted in the Extend Gross Premium Tax – Incr. Capitation Rates policy change. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period and will be matched with federal funds at the level in effect at that time.

Capitation rate increases due to the GPT are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the GPT fund on a quarterly basis.

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 133

These funding adjustments reflect GPT amounts that were used to increase capitation rates in prior periods.

The GPT dollars come from the FY 2011-12 Ventura IGT, the FY 2011-12 GMC IGT, and the FY 2011-12 Two-Plan IGT, which are being paid in 2013-14. The GPT for the FY 2012-13 IGTs is budgeted in the Extend Gross Premium Tax – Incr. Capitation Rates policy change.

Reason for Change from Prior Estimate:
Changes are due to the additional GMC IGT for the FY 2011-12 period.

Methodology:
1. Funding adjustments for FY 2013-14 will be made in the amount of $5,557,000 for FY 2011-12 IGTs.

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

	FY 2013-14
Total Gross Premium Tax	$5,557,000
GF	($5,557,000)
Total	**$0**

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

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1647

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

*****SUBJECT TO REVISION*****

Purpose:
This policy change estimates the transfer of funds collected from the Gross Premium Tax Fund to the General Fund (GF) to be retained by the Department.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Background:
SB 78 was signed by the Governor on June 27, 2013, and extends the gross premium tax sunset date that through June 30, 2013. Prior to October 1, 2012 transition of the Healthy Families Program to Medi-Cal, the portion of the gross premium tax shown in this policy change was used to fund the Healthy Families Program. Beginning October 1, 2012, this portion of the tax will be retained by the Department to offset GF cost for the Medi-Cal program. This policy change estimates GF savings resulting from the extension of the gross premium tax sunset date through June 30, 2013. Due to a delay in approval, the FY 2012-13 payments are not expected to be made until FY 2013-14.

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

Methodology:
1. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. The FY 2012-13 impact of the increase in capitation payments related to the gross premium tax is included in the Extend Gross Premium Tax – Incr. Capitation Rates policy change.

3. The total available Gross Premium Tax revenue in FY 2013-14 is estimated to be $191,721,000. Of this amount MRMIB will receive $128,102,000. The Department will receive $63,619,000.

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EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 134

The gross premium tax fund transfers to the GF are expected to be:

FY 2013-14	GF	Gross Premium Tax	TF
Gross Premium Tax	$ (191,721,000)	$ 191,721,000	**$ 0**
Amount to MRMIB	$ 128,102,000	$ (128,102,000)	**$ 0**
Total	$ (63,619,000)	$31,809,000	**$ 0**

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

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MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	7/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1601

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

Authority:
AB 102 (Chapter 29, Statutes of 2011)

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 counties or other approved public entities transfer funds as IGTs to the Department to provide capitation rate increases to the managed care plans. These funds provide the nonfederal share of capitation rate increases, which are budgeted in the Managed Care Rate Range IGT policy change. The Department develops an actuarially sound rate range that consists of a lower and upper bound rate. The state has the option of paying plans any rate that is within the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Per AB 102, beginning July 1, 2011, the Department began charging counties or other approved public entities a 20% administrative and processing fee for their IGTs. These fees are not charged for certain IGTs related to designated public hospitals and IGTs authorized pursuant to Welfare & Institutions Code Sections 14168.7 and 14182.15.

Reason for Change from Prior Period:
The policy change was revised to incorporate updated IGT amounts.

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MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 135

Methodology:

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

2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.

(In Thousands)	IGT amount subject to the fee	20% Admin. & Processing Fee		Support Cost Reimbursement to GF		Local Assistance Reimbursement to GF
FY 2013-14	$ 355,299	$ 71,060	-	$ 251	=	**$ 70,809**
FY 2014-15	$ 391,448	$ 78,290	-	$ 251	=	**$ 78,039**

Funding:

100% State GF (4260-101-0001)
Reimbursement (4260-610-0995)

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GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1605

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will reimburse the General Fund (GF) for the costs built into the managed care baseline capitation rates.

Authority:
SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
Effective June 1, 2011, SPDs who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Since 2005, the inpatient care for fee-for-service (FFS) members receiving services at a DPH facility has been reimbursed under a cost-based payment and financing structure. The DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided. It is important to note that as a result of this funding arrangement, the State was not providing the state\local match requirement. Instead, the CPE process satisfied the state\local match requirement. Due to this payment structure, the transition of FFS Seniors and Persons with Disabilities (SPDs) to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while at the same time ensuring that there are not new State GF expenditures. Other, non-inpatient services provided within the FFS structure by a DPH or its affiliated governmental entities (collectively, Public Providers) were being reimbursed through a combination of regulatory FFS rates, for which the nonfederal share was supported with State GF, and supplemental reimbursement above the FFS fee schedule, financed through the CPE mechanism, for the otherwise unreimbursed allowable costs of the services. The services for which these FFS supplemental

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 136

reimbursement mechanisms apply include hospital outpatient, physician and non-physician practitioner professional, and non-hospital clinic services but does not include federally qualified health center (FQHC) services. These FFS payment structures no longer occur with respect to SPD beneficiaries that have transitioned to the managed care payment environment. Therefore, appropriate rate and other funding adjustments needed to be developed to reflect the historical patient reimbursement provided by these FFS methodologies in order to ensure access to services and adequate funding to these critical safety net providers.

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs.

In FY 2012-13, the DPHs began reimbursing the GF through an IGT for costs that are built into the managed care baseline capitation rates that would not have been incurred had the SPDs remained in FFS.

Reason for Change from Prior Estimate:
Numbers have been updated with actual dollar amounts. Additionally, Year 3 payments were delayed from FY 2013-14 to FY 2014-15.

Methodology:

1. Determine the baseline of DPH inpatient services/costs in FFS that are subject to transition into managed care.

2. Account for managed care factors applied in the capitation rate development process.

3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization, which yields the calculated historical DPH allowable cost per day and related utilization.

4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rate for transitioned members.

5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members' baseline capitation rates.

6. The initial (Year 1) GF reimbursement includes the period of July 1, 2011, through December 31, 2012, for the GMC model counties, and July 1, 2011, through September 30, 2012, for the Two-Plan model counties. An estimated reimbursement in the amount of $86,847,000 was made in FY 2012-13.

7. The Year 2 reimbursement will include the period of January 1, 2013, through December 31, 2013, for the GMC model counties, and October 1, 2013, through September 20, 2013, for the Two-Plan model counties. An estimated reimbursement in the amount of $80,436,000 is expected to be made in FY 2013-14.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 136

8. The Year 3 reimbursement will include the period January 1, 2014, through June 30, 2014, for the GMC model counties, and October 1, 2013, through June 30, 2014, for the Two-Plan model counties. The reimbursement has not yet been calculated; therefore, a placeholder in the amount of $53,080,000 is estimated for FY 2014-15.

9. The Year 4 reimbursement will include the period of July 1, 2014 through June 30, 2015 for both, the GMC and the Two-Plan model counties. Reimbursement for that fiscal year is estimated to be $80 million. Of that amount, approximately half ($40 million) is estimated to be collected in FY 2014-15.

	FY 2013-14	FY 2014-15
Year 2 Reimbursement from DPHs	$ 80,436,000	$ 0
Year 3 Reimbursement from DPHs	$ 0	$ 53,080,000
Year 4 Reimbursement from DPHs	$ 0	$ 40,000,000
Total Reimbursement	$ 80,436,000	$ 93,080,000
GF	($ 80,436,000)	($ 93,080,000)
Net Impact	**$ 0**	**$ 0**

Funding:
Reimbursement (4260-610-0995)
100% State GF (4260-101-1001)

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EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1655

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds from the Gross Premium Tax Fund to the General Fund as a result of a proposal to extend the Gross Premium Tax.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and extended the collection of a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2013. The proceeds from the tax are used to offset capitation rates. Due to a delay in approval, the FY 2012-13 transfer is not expected to occur until FY 2013-14.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis.

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

Methodology:
1. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. Assume that transfers from the Department of Insurance take place three months after quarterly tax payments.

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EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 137

The gross premium tax fund transfers to the GF are expected to be:

	GF	Gross Premium Tax	TF
FY 2013-14	$ (191,721,000)	$ 191,721,000	**$ 0**

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

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FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER:	138
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1082

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change is for informational purposes only.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Updated FFS payment information.

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FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 138

Methodology:
In Fiscal Year 2012-2013 FFS payments for managed care enrollees totaled:

	Expenditures by Aid Category		
	Other	**CCS/GHPP**	**Total**
Families	$398,118,000	$517,219,000	$915,337,000
Disabled	$381,271,000	$570,039,000	$951,310,000
Aged	$97,347,000	$0	$97,347,000
200% Poverty	$13,982,000	$32,408,000	$46,390,000
MI Child	$10,026,000	$19,852,000	$29,878,000
133% Poverty	$12,695,000	$11,696,000	$24,391,000
Other	$1,862,000	$17,000	$1,879,000
100% Poverty	$11,496,000	$25,418,000	$36,914,000
Blind	$9,803,000	$14,429,000	$24,232,000
MI Adult	$2,461,000	$481,000	$2,942,000
Totals	**$939,061,000**	**$1,191,559,000**	**$2,130,620,000**

Funding:
Not Applicable

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MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1782

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 140 MCO Tax Managed Care Plans

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be retained by the Department to offset GF cost for capitated rate increases as a result of the imposition of the tax. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change from Prior Estimate:
Updated FY 2013-14 rates and new FY 2014-15 rates.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 139

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans– Incr. Cap. Rates policy change.

6. Adjustment amounts include the impact of the ACA Optional and Mandatory Expansions.

The MCO tax fund transfers to the GF are expected to be:

	GF	MCO Tax	TF
FY 2013-14	$ (260,111,000)	$ 260,111,000	**$ 0**
FY 2014-15	$ (476,655,000)	$ 476,655,000	**$ 0**

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

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MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	140
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1783

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2013.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be continuously appropriated to the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates GF savings resulting from the imposition of the MCO tax.

Reason for Change from Prior Estimate:
Updated FY 2013-14 rates and new FY 2014-15 rates.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 140

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

6. The impact of the MCO tax is included in the ACA Optional Expansion and the ACA Mandatory Expansion policy changes.

The MCO tax fund transfers to the GF are expected to be:

	GF	MCO Tax	TF
FY 2013-14	$ (256,450,000)	$ 256,450,000	**$ 0**
FY 2014-15	$ (462,329,000)	$ 462,329,000	**$ 0**

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

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SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER:	141
IMPLEMENTATION DATE:	1/2015
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1749

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the capitated payments associated with the transition of Medi-Cal beneficiaries out of Senior Care Action Network (SCAN) and into Coordinate Care Initiative (CCI) managed care plans.

Authority:
Welfare & Institutions Code 14204

Interdependent Policy Changes:
Not Applicable

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.

The Department does not plan to renew the SCAN contract. The Department executed a one-year contract extension for January 1, 2014 through December 31, 2014. The contract extension facilitates transition of the SCAN Medi-Cal population into CCI managed care plans.

Reason for Change from Prior Estimate:
The Department executed an additional one-year extension of the SCAN contract, resulting in a delay in transitioning SCAN members into managed care.

Methodology:

1. Assume the transition of total SCAN membership will occur on January 1, 2015.

2. Assume the transition of total SCAN membership into the CCI managed care plan of the beneficiary's choice.

3. Assume the cost of SCAN members will be reflected in the capitation rate of the chosen

SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 141

managed care plan.

4. Assume SCAN beneficiaries will continue to enroll into managed care plans for the period of January 1, 2015 through June 30, 2015 at the same rate as during FY 2013-14.

5. The managed care rates used to estimate these costs are based on a weighted average of managed care rates by aid code for Los Angeles, Riverside, and San Bernardino counties.

6. The Department does not anticipate a fiscal impact.

FY 2014-15	Eligible Months	Managed Care	SCAN	Total
Los Angeles	32,060	$13,187,000	($13,187,000)	$0
Riverside	10,235	$3,879,000	($3,879,000)	$0
San Bernardino	6,585	$2,695,000	($2,695,000)	$0
Total	48,880	$19,761,000	($19,761,000)	**$0**

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

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DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	10/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1482

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,100,000	$0
- STATE FUNDS	-$550,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,100,000	$0
STATE FUNDS	-$550,000	$0
FEDERAL FUNDS	-$550,000	$0

DESCRIPTION

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

Authority:
Contract 08-85215

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

Reason for Change from Prior Estimate:
Updated rates.

Methodology:
1. It is assumed the annual member months for undocumented beneficiaries in FY 2013-14 will be 3,430 for Solano County, 1,718 for Napa County, and 1,880 for Yolo County.

2. The FY 2013-14 undocumented beneficiary rates are assumed to be $352.33 for Solano County, $843.95 for Napa County, and $605.86 for Yolo County.

3. The FY 2013-14 cost, for period October 1, 2013 through June 30, 2014, for undocumented

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 142

beneficiaries by county is expected to be:

Solano County:	3,430 x $352.33 x .75 = $ 906,000
Napa County:	1,718 x $843.95 x .75 = $1,087,000
Yolo County:	1,880 x $605.86 x .75 = $ 854,000

$906,000 + $1,087,000 + $854,000 = $2,847,000

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

FY 2013-14	$2,847,000	FFS cost
	($2,847,000)	Managed Care savings
	$0	FY 2013-14 impact of shift to FFS

5. There will be a net savings in FY 2013-14 due to the capitation payments ending on September 30, 2013. There will be a lag in FFS payments due to the time it takes for providers to bill and be paid for services.

	FY 2013-14
Managed Care Savings	($2,847,000)
FFS Cost	$2,847,000
FFS Payment Lag	0.6138
Lagged FFS Costs	$1,747,000
Net costs (Rounded)	**($1,100,000)**

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

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TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	6/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1641

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$140,711,000	-$3,788,843,000
- STATE FUNDS	-$70,355,500	-$1,894,421,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$140,711,000	-$3,788,843,000
STATE FUNDS	-$70,355,500	-$1,894,421,500
FEDERAL FUNDS	-$70,355,500	-$1,894,421,500

DESCRIPTION

Purpose:
This policy change estimates the savings from transitioning dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long-Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
PC 119 Transition of Dual Eligibles-Managed Care Payments
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:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) as well as Medi-Cal only beneficiaries. By enrolling these eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

The CCI will mandatorily enroll dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services. The managed care payments assume immediate savings.

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

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TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 143

The transitions and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS.

Reason for Change from Prior Estimate:
The implementation changed from January 2014 to April 2014. Additionally, the phase-in schedule has been revised.

Methodology:

1. Assume Dual Eligibles in the Medicare fee-for-service (FFS) program populations receiving LTC institutional and community-based services under the traditional Fee-for-Service (FFS) model will begin enrolling into the CCI on April 1, 2014. Medicare FFS beneficiaries from San Mateo County will phase-in over 3 months. Medicare FFS beneficiaries from the other seven counties will phase-in over 12 months. Dual Eligibles in Alameda and Santa Clara will be enrolling in the demonstration starting in July 2014.

2. Beneficiaries enrolled in a Medicare Advantage plan will have their Medi-Cal benefits transition from FFS to managed care beginning in July 2014. Medicare Advantage beneficiaries from San Mateo County will phase-in over 3 months. Medicare FFS beneficiaries from the other seven counties will phase-in over 12 months.

3. In January 2015, Medicare Advantage eligibles will enroll in the CCI. All remaining Medicare Advantage eligibles that have not yet phased-in from Medi-Cal FFS to Medi-Cal managed care will transition in January 2015.

4. Medi-Cal only eligibles and those receiving only partial Medicare coverage will have their LTC and community-based services included in Medi-Cal managed care beginning in July 2014. This phase-in over 12 months.

5. Assume there are an estimated 1,019,000 beneficiaries in April 2014 who will start to receive the enhanced LTSS services from a managed care plan in the eight pilot counties. 381,000 of these beneficiaries are dual eligibles who will be enrolled into the demonstration.

6. Assume for participating dual eligibles, there will be an overall average 1.15% savings in FY 2013-14 and FY 2014-15.

7. The delay in checkwrite is shown here for display purposes. The FFS savings due to the CCI will result in a loss of savings in the delay of the checkwrite. The delay in checkwrite for FY 2013-14 is captured in the base trend data.

8. Estimated below is the overall impact of the Dual and LTC Integration proposal in FY 2013-14 and FY 2014-15.

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TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 143

(In Thousands)

FY 2013-14	TF	GF	FFP	Reimbursement
Managed Care Payments (PC 119):				
Non HCBS	$72,206	$36,103	$36,103	$0
HCBS	$53,221	$25,245	$27,976	$0
Existing Managed Care Duals	($149)	($75)	($74)	$0
Total	$125,278	$61,273	$64,005	$0
FFS Savings (PC 143):				
Non HCBS	($50,440)	($25,220)	($25,220)	$0
HCBS	($164)	($82)	($82)	$0
Defer Mgd. Care Payment	($90,107)	($45,054)	($45,053)	$0
Total	**($140,711)**	**($70,356)**	**($70,355)**	**$0**
IHSS FFS Savings (In the Base)	($21,973)	$0	($21,973)	$0
Delay 1 Checkwrite (In the Base)	$6,326	$3,163	$3,163	$0
Transfer of IHSS Costs to DHCS (PC 197)	$0	($21,973)	$0	$21,973
Transfer of IHSS Costs to CDSS (PC 123)	$45,505	$0	$0	$45,505
Other Administration Costs (OA 19)	$8,786	$2,543	$6,243	$0
Total of CCI PCs including pass through	$23,211	($25,350)	($18,917)	$67,478

(In Thousands)

FY 2014-15	TF	GF	FFP	Reimbursement
Managed Care Payments (PC 119):				
Non HCBS	$3,811,408	$1,905,704	$1,905,704	$0
HCBS	$1,898,211	$900,636	$997,575	$0
Existing Managed Care Duals	($2,715)	($1,358)	($1,357)	$0
Total	$5,706,904	$2,804,982	$2,901,922	$0
FFS Savings (PC 143):				
Non HCBS	($3,152,713)	($1,576,357)	($1,576,356)	$0
HCBS	($11,556)	($5,778)	($5,778)	$0
Defer Mgd. Care Payment	($624,574)	($312,287)	($312,287)	$0
Total	**($3,788,843)**	**($1,894,422)**	**($1,894,421)**	**$0**
IHSS FFS Savings (In the Base)	($782,780)	$0	($782,780)	$0
Delay 1 Checkwrite (In the Base)	$85,162	$42,581	$42,581	$0
Transfer of IHSS Costs to DHCS (PC 197)	$0	($782,780)	$0	$782,780
Transfer of IHSS Costs to CDSS (PC 113)	$1,615,660	$0	$0	$1,615,660
Other Administration Costs (OA 19)	$8,070	$2,543	$5,527	$0
Total of CCI PCs including pass through	$2,844,173	$172,905	$272,829	$2,398,440

Funding:

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

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FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	144
IMPLEMENTATION DATE:	7/2008
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1329

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$278,268,000	$207,969,000
- STATE FUNDS	$139,134,000	$103,984,500
PAYMENT LAG	0.9823	0.9888
% REFLECTED IN BASE	29.86 %	1.23 %
APPLIED TO BASE		
TOTAL FUNDS	$191,722,500	$203,110,400
STATE FUNDS	$95,861,270	$101,555,190
FEDERAL FUNDS	$95,861,270	$101,555,190

DESCRIPTION

*****SUBJECT TO REVISION*****

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

Authority:
Welfare & Institutions Code, section 14170

Interdependent Policy Changes:
Not Applicable

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

CBRCs, owned or operated by Los Angeles County, are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The FY 2008-09 audited levels were used to update the CBRC rates as of July 1, 2013. The Department is scheduled to complete the CBRC reconciliation audit for FY 2009-10 in FY 2013-14 and for FY 2010-11 in FY 2014-15. Interim rates will be adjusted to the FY 2009-10 audited levels beginning in FY 2013-14, and to the FY 2010-11 audited levels in FY 2014-15.

Currently, there are 773 active FQHCs, 274 active RHCs and 29 active CBRCs.

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FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 144

Reason for Change from Prior Estimate:
There was a retroactive recoupment that was paid in August 2013.

Methodology:

1. The estimated FQHC/RHC's reconciliation for each fiscal year respectively is based on a three year average of the reported settlement amount versus actual settlement. The LA CBRC Reconciliation decrease from $80,954,000 to $60,318,000 may be attributed to hospital closures and/or ancillary facilities no longer utilizing the hospitals' PPS rate.

2. The LA CBRC reconciliation of $80,954,000 was calculated based on estimated settlement of approximately 91.2% of the 2009 Reported Settlement for FY 2013-14. However, FY 2014-15 was based on a 95% calculation of the 2011 reported settlements. Fiscal years are expected to increase by 5.13% based on reported costs for the fiscal years of 2007-2012.

3. The July 1, 2013 CBRC rate increase $34,041,000 is based on the 2009 Audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2011-12. The estimated payment is determined by multiplying the total visits obtained from the Paid Claims Summary Reports for FY 2011-12 and the 2009 Audited Rate. Additionally, the estimated payment increase is determined by the difference between the calculated estimated payment and the total payments per the Paid Claims Summary Reports for FY 2011-12.

4. The July 1, 2014 CBRC rate increase of $14,792,000 is based on the 2009 Audited PPS rate utilizing payment data obtained from the Paid Claims Summary Reports for Fiscal Year ending June 30, 2013. Additionally, the estimated payment increase is determined by the difference between the calculated estimated payment and the total payments per the Paid Claims Summary reports for FY 2012-13.

5. In August 2013, there was a retroactive rate adjustment payout from old claims dating back to January 2006 of $77,000,000.

(In Thousands)	FY 2013-14	FY 2014-15
FQHCs Reconciliation	$81,390	$89,288
RHCs Reconciliation	$4,883	$9,530
FQHC Retroactive Rate Adjustment	$77,000	
LA CBRCs Reconciliation	$80,954	$60,318
July 2012 LA CBRC Rate Increase	$34,041	$34,041
July 2013 LA CBRC Rate Increase		$14,792
Total	**$278,268**	**$207,969**

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

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AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	2/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1508

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$77,983,000	$200,086,000
- STATE FUNDS	$38,991,500	$100,043,000
PAYMENT LAG	0.8720	0.9349
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$68,001,200	$187,060,400
STATE FUNDS	$34,000,590	$93,530,200
FEDERAL FUNDS	$34,000,590	$93,530,200

DESCRIPTION

Purpose:
This policy change estimates the cost of the AB 1629 rate increases for freestanding skilled nursing facilities (NF-Bs), which is partially funded by the Quality Assurance Fee (QAF).

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)
AB 1489 (Chapter 631, Statutes of 2012)

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 Managed Care Plans

Background:
AB 1629 requires the Department to implement a facility-specific rate methodology and impose a QAF on NF-Bs, including adult and pediatric subacute facilities. The QAF is used to offset the GF portion of the reimbursement rates.

The QAF is used as a means to enhance federal financial participation (FFP) for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

To determine the QAF amount assessed to these facilities, the Department uses two-year old data as the base revenue and applies growth and trending adjustments to project an estimate of revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is 6%, effective October 1, 2011. Changes in the amount of licensing and certification fees for NF-Bs, assessed by the California Department of Public Health (CDPH), affect the amount of QAF that can be collected in order to remain within the federal safe harbor limit.

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA)

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 145

Fund. Effective August 1, 2013, the revenue generated by the QAF collections will be deposited directly into the fund, rather than the state General Fund (GF), and will be used to offset provider reimbursement rate expenditures. AB 1489 implemented a 3% increase to the weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years.

Reason for Change from Prior Estimate:

- This policy change now includes the cost of rate increase previously budgeted in the AB 1629 Add-Ons policy change.
- Costs for 2013-14 rate increase were included in FY 2013-14 managed care capitation rates.

Methodology:

1. The amounts reflected below are based upon rate year beginning August 1, 2013.

2. AB 1489 implemented a 3% rate increase for the 2013-14 and 2014-15 rate years.

3. The General Fund amount shown here is equal to the QAF revenue deposited in the State's General Fund, on an accrual basis.

4. The estimated 11-month impact of the August 1, 2013 rate adjustment in FY 2013-14 is already included in the managed care FY 2013-14 capitation rates.

(Dollars In Thousands)

FY 2013-14	**TF**	**GF**	**FF**
FFS	$35,447	$17,724	$17,724
Retroactive Payments-FFS	$42,536	$21,268	$21,268
Total*	**$77,983**	**$38,992**	**$38,992**

FY 2014-15	**TF**	**GF**	**FF**
FFS	$165,396	$98,026	$98,026
Managed Care	$34,690	$20,388	$20,388
Total*	**$200,086**	**$118,414**	**$118,414**

Funding:

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

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QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	4/2014
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1563

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$40,673,000	$42,657,000
- STATE FUNDS	$20,336,500	$21,328,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,673,000	$42,657,000
STATE FUNDS	$20,336,500	$21,328,500
FEDERAL FUNDS	$20,336,500	$21,328,500

DESCRIPTION

Purpose:
This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to freestanding nursing facilities (NF-Bs) through the Special Fund.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments program for NF-Bs. The supplemental payments will be tied to demonstrated quality of care improvements. Supplemental payments will begin in April 2014 and will be paid through the Special Fund. The Special Fund will be comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, 1% of the weighted average rate increase on NF-Bs, and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change from Prior Estimate:
The changes are due to updated penalties collection and 1% of the weighted average rate increase.

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QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 146

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

2. The estimated incoming funds for the Special Fund are:

	FY 2013-14	FY 2014-15
Penalties on Nursing Facilities	$995,000	$600,000
1% Weighted Average Rate Increase	$20,302,308	$20,911,429
PLI Savings	$4,250,000	$4,250,000

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments will be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.

4. Estimated CDPH administrative costs are $2,780,000 in FY 2013-14 and $2,533,000 in FY 2014-15.

5. Supplemental payments are estimated to be $40,673,000 TF ($20,336,500 SP) in FY 2013-14 and $42,657,000 TF ($21,328,500 SP) in FY 2014-15.

(Dollars In Thousands)

	TF	GF	SF	FF
FY 2013-14				
Supplemental Payments***	$40,673	$0	$20,336	$20,336
Transfer from GF* to Special Fund**	$0	$24,552	($24,552)	$0
Total	**$40,673**	**$24,552**	**($4,216)**	**$20,336**
FY 2014-15				
Supplemental Payments***	$42,657	$0	$21,328	$21,328
Transfer from GF* to Special Fund**	$0	$25,161	($25,161)	$0
Total	**$42,657**	**$25,161**	**($3,833)**	**$21,328**

Funding:

100% GF (4260-605-0001)*
SNF Quality & Accountability (less funded by GF) (4260-698-3167)**
SNF Quality & Accountability (4260-605-3167)***
Title XIX FFP (4260-101-0890)***

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AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	11/2012
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1612

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$24,216,000	$16,394,000
- STATE FUNDS	$12,108,000	$8,198,000
PAYMENT LAG	0.7623	0.8913
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,459,900	$14,612,000
STATE FUNDS	$9,229,930	$7,306,880
FEDERAL FUNDS	$9,229,930	$7,305,100

DESCRIPTION

Purpose:
This policy change estimates the increase in payments and the offset of General Fund (GF) of the Medi-Cal reimbursement rate for emergency medical air transportation services.

Authority:
AB 2173 (Chapter 547, Statutes of 2010), Government Code 76000.10
AB 215 (Chapter 392, Statutes of 2011), Government Code 76000.10

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:
AB 2173 imposed an additional penalty of $4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill requires the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Air Medical Transportation Act (EMATA) Fund.

AB 215 eliminated the county's administrative costs by allowing the counties to remit their collections to the State under an existing process established in current law. This change in remittance procedures increases the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the remaining EMATA funds will be used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the fund will be matched with federal funds and used to augment the rate for medical emergency Medi-Cal air medical transportation services.

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 147

Federal approval to distribute EMATA funds to emergency air medical transportation providers was obtained on November 12, 2012. In the initial phase, the Department provided supplemental payments for Medi-Cal air medical transportation services provided to Medi-Cal beneficiaries from January 7, 2012 to June 30, 2012 (Phase I). Upon federal approval for the second phase, effective from July 1, 2012 to June 30, 2017 (Phase II), the Department will provide payment augmentations to air medical transportation services. The payment augmentation per transport amount will be calculated annually.

Reason for Change from Prior Estimate:
The change is due to:

- The Phase II implementation date changed from June 2013 to February 2014 because of delay in expected federal approval and implementing necessary system changes,
- No 25% reserve fund, and
- Revised penalty collections.

Methodology:

1. Implementation date began November 2012.

2. Phase I: Supplemental Payments
   $7,641,000 EMATA funds were used to calculate supplemental payments. 20% of this amount was used to offset the FY 2011-12 GF costs of fee-for-service (FFS) emergency air medical transportation services. The remaining 80% was matched with federal funds and paid as supplemental payments in FY 2012-13 to FFS air medical transportation providers.

   $7,641,000 X 20% = $1,528,000 (GF offset)
   $7,641,000 - $1,528,000 = $6,113,000 X 2 = $12,226,000 ($6,113,000 EMATA Fund)

3. Phase II: Payment Augmentations
   Payment augmentations for medical emergency Medi-Cal air medical transportation services will be adjusted annually based on penalties collected from most vehicle violation convictions. 20% of the amount will be used to offset GF costs of emergency air medical transportation services for the same fiscal year. The remaining 80% will be matched with federal funds and used to augment the rate for FFS and managed care air medical transportation services.

4. The estimated EMATA funds for the Phase II on an accrual basis are:

		EMATA Fund	GF Offset (20%)	Available for Rate Augmentation
FY 2013-14				
2012-13		$4,890,000	$978,000	$3,912,000
2013-14		$10,246,000	$2,049,200	$8,196,800
	Total	$15,136,000	$3,027,200	$12,108,800
FY 2014-15		$10,246,000	$2,049,200	$8,196,800

5. The estimated payments on a cash basis are:

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AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 147

(Dollars in Thousands)				
FY 2013-14	**TF**	**GF**	**EMATA**	**FFP**
GF Offset	$0	($3,027)	$3,027	
Fee For Services	$18,162		$9,081	$9,081
Managed Care	$6,054		$3,027	$3,027
Total	**$24,216**	**($3,027)**	**$15,135**	**$12,108**
FY 2014-15				
GF Offset	$0	($2,049)	$2,049	
Fee For Services	$12,295		$6,148	$6,147
Managed Care	$4,099		$2,050	$2,049
Total	**$16,394**	**($2,049)**	**$10,247**	**$8,196**

Funding:
State GF (4260-101-0001)
Title XIX (4260-101-0890)
EMATA Fund (4260-101-3168)

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	148
IMPLEMENTATION DATE:	8/2007
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1046

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$19,783,000	$108,753,000
- STATE FUNDS	$9,891,500	$54,376,500
PAYMENT LAG	0.8838	0.9033
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,484,200	$98,236,600
STATE FUNDS	$8,742,110	$49,118,290
FEDERAL FUNDS	$8,742,110	$49,118,290

DESCRIPTION

Purpose:
This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-As (NF-A), Distinct Part Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, Distinct Part (DP) Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. Additionally, it estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF-DDs and Freestanding (FS) Pediatric Subacute facilities. It also estimates the additional reimbursement for the projected Medi-Cal costs of complying with new State or federal mandates, referred to as “add-ons.”

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 152 Non-AB 1629 LTC Rate Freeze
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:
Pursuant to the State Plan requirements, Medi-Cal rates for LTC facilities are adjusted after completion of an annual rate study.

ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

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LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 148

Effective June 1, 2011, AB 97 requires the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition, AB 97 extends this requirement to the other long term care facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers, effective August 1, 2012. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% reduction and rate freeze at the 2008-2009 rate level, required by AB 97, with respect to DP/NF-Bs. On December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction.

On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunctions. The Department will implement the AB 97 payment reduction and rate freeze retroactive to June 1, 2011.

The Department elected not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its access and utilization analyses. CMS approved the Department's request not to implement a rate freeze on DP Adult Subacute and DP Pediatric Subacute rates.

The Department will submit a request to CMS to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels in addition to the 10% payment reduction, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and 10% payment reduction, effective October 1, 2013.

Reason for Change from Prior Estimate:

- Delay in implementation due to pending SPA approvals, ongoing litigation, and additional workload that the litigation has created for the Fiscal Intermediary.
- Implementation of new reimbursement rate methodology for ICF/DD, ICF/DD-H, and ICF/DD-N facilities.
- Updated rate information.
- Costs for 2013-14 rate adjustment and add-ons were included in FY 2013-14 managed care capitation rates.

Methodology:

1. No rate increase is assumed for NF-As, Rural Swing Beds, and FS Pediatric Subacute facilities during rate year (RY) 2013-14 and 2014-15.

2. The add-ons are negotiated on an annual basis and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific reimbursement rates. These new mandated costs are budgeted separately, as they will take two years to be reflected in the regular facility specific reimbursement rates.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 148

3. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze.

4. **DP Adult Subacute and DP Pediatric Subacute facilities**: These two facilities will not be subject to any rate reductions. The Department completed a "Monitoring Access to Medi-Cal Covered Services" study that determined reducing or freezing reimbursement rates for these two facilities would negatively impact access to care. Therefore, the Department will be increasing reimbursement rates for these facility types under the "normal" rate setting process.

5. **DP/NF-B facilities:** Rates are currently paid at the 2011-12 level. The impact of implementation of AB 97 rate freeze and SB 239 exemption is budgeted in the Non-AB 1629 LTC Rate Freeze policy change.

6. **ICF/DD, ICF/DD-H, and ICF/DD-N facilities:** Rate are currently paid at the 2008-09 levels. The Department will implement the 12-13 rate using the new rate methodology in April 2014.

7. ABX1 19 requires FS Pediatric Subacute Care facilities to pay a QA fee beginning January 1, 2012. Effective October 1, 2011, the QA fee cap increased from 5.5% to 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.

8. Effective October 1, 2010, CMS mandated that FS skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0). Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. The rate increase was effective August 1, 2011. The rate increase for FY 2013-14 and FY 2014-15 will be $0.51. For NF-A, the FY 2012-13 add-on is $1.75.

9. Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional cost was effective August 1, 2011. For FY 2013-14 and FY 2014-15, the add-on for the above-mentioned providers will be $0.25 excluding ICF/DD-H and ICF/DD-N facilities, who will receive $0.48.

10. Adult Day Holiday mandated add-on reimburses ICF/DD facilities for adult day care or transportation service during the period between Christmas and New Years. A $0.16 add-on to the rate to reimburse facilities is in effect for 2013-14 and 2014-15 rate years. The ICF/DD-N facilities will receive $0.22.

11. Effective January 2011, the California Department of Public Health (CDPH) mandates LTC facilities to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to January 2011. An add-on from $0.11 through $0.19 to the rates to reimburse the facilities for the additional costs is effective for the 2013-14 and 2014-15 rate years.

12. The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on from $0.11 through $0.17 to the rate to reimburse facilities will be effective for the 2013-14 and 2014-15 rate years.

13. Effective April 2012, CDPH requires providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on to the rates to

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 148

reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to April 2012. An add-on from $0.02 through $0.04 to the rates to reimburse the facilities for the additional costs is effective for the 2013-14 and 2014-15 rate years excluding ICF/DD, ICF/DD-H and ICF/DD-N facilities.

14. Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An Elder Justice Act add-on from $0.01 through $0.04 reimburses LTC facilities for compliance costs. This add-on is in effect for 2013-14 and 2014-15 rate years.

15. The Patient Protection and Affordable Care Act (ACA) assessed two new fees on employers providing health insurance, an annual reinsurance fee, effective January 1, 2014 and a Patient-Centered Outcomes Research Trust Fund Fee (PCORI) per covered life, effective December 6, 2012. An add-on of $0.04 will be effective for the 2013-14 rate year and $0.07 for the 2014-15 rate year.

16. Effective March 23, 2013, the ACA requires Skilled Nursing Facilities to implement a compliance and ethics program. An add-on of $0.66 will be provided to cover costs associated with implementing this program and will be effective for the 2013-14 and 2014-15 rate years excluding ICF/DD, ICF/DD-H and ICF/DD-N facilities.

17. The Health Insurance and Portability and Accountability Act (HIPAA) issued new regulations regarding the use of electronic fund transfers (EFT) and electronic remittance advices (RA). A $0.03 add-on will be provided for associated training costs and will be effective for the 2013-14 and 2014-15 rate years excluding ICF/DD-H and ICF/DD-N facilities.

18. Assume the annual rate increase costs for managed care plans are $6,513,000. The estimated 11-month impact of the August 1, 2013 rate increase in FY 2013-14 is already included in managed care FY 2013-14 capitation rates.

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LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 148

(Dollars in Thousands)

Fee-for-Service	**FY 2013-14**	**FY 2014-15**
DP Adult Subacute Rate Increase (12-13)	($795)	($867)
DP Adult Subacute Rate Increase (13-14)	$8,428	$20,228
DP Pediatric Subacute Rate Increase (13-14)	$330	$793
FS Pediatric Subacute QAF Impact (12-13)	$171	$256
FS Pediatric Subacute QAF Impact (13-14)	$95	$228
ICF DD (12-13)	($1,714)	($6,855)
ICF DD (13-14)	($931)	($3,726)
Retro Rate Adjustment	$9,766	$0
MDS 3.0	$49	$10
Vaccine	$529	$106
Informed Consent	$86	$17
FUTA	$506	$101
Std Adm Agreement	$17	$3
Elder Justice Act	$49	$10
Adult Day Holiday	$197	$39
New - ACA Reinsurance Fee & PCORI	$64	$13
New - ACA Compliance Program	$491	$98
New - HIPPA EFT and RA	$26	$5
Retro Add-ons (13-14)	$2,419	$0
DP Adult Subacute Rate Increase (14-15)		$18,021
DP Pediatric Subacute Rate Increase (14-15)		$902
FS Pediatric Subacute QAF Impact (14-15)		$233
DP/NF-B Rate Increase (13-14)		$26,944
DP/NF-B Rate Increase (14-15)		$20,917
ICF DD (14-15)		$2,470
Retro Rate Adjustment		$18,043
MDS 3.0		$109
Vaccine		$1,164
Informed Consent		$60
FUTA		$996
Std Adm Agreement		$15
Elder Justice Act		$97
Adult Day Holiday		$434
New - ACA Reinsurance Fee & PCORI		$238
New - ACA Compliance Program		$1,081
New - HIPPA EFT and RA		$57
Total FFS	$19,783	$102,240
Managed care	$0	$6,513
Total Cost	**$19,783**	**$108,753**

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

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ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER:	149
IMPLEMENTATION DATE:	10/2005
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	88

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$61,660,000	$15,823,000
- STATE FUNDS	$30,830,000	$7,911,500
PAYMENT LAG	0.9783	0.9117
% REFLECTED IN BASE	90.87 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,507,400	$14,425,800
STATE FUNDS	$2,753,700	$7,212,910
FEDERAL FUNDS	$2,753,700	$7,212,920

DESCRIPTION

Purpose:
This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

Authority:
Section 1833 of the Social Security Act

Interdependent Policy Changes:
Not Applicable

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the MEI and is effective October 1st of each year.

Reason for Change from Prior Estimate:
There is an increase in the cost per visit due to the increase in the MEI percentage. The cost per visit increased from FY 2011-12 to FY 2012-13.

Methodology:
1. Assume utilization will increase 3.45% in year 2013 and 0.38% in year 2014. Utilization is based on the average percent increase of visits over the past three preceding years.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 149

2. Apply the utilization factors to the actual 2012 visits.

2012 Visits		**2013 Visits**
10,179,009	3.45%	10,530,656
2013 Visits		**2014 Visits**
10,530,656	0.38%	10,570,222

3. The annual MEI increase will be used as a trend factor to calculate the estimated cost per visit (rate). The MEI increase percent is 0.6% for year 2012. The MEI increase percent for year 2013 and 2014 is 0.8%. Therefore, the rates are:

	Rate without MEI	Rate with MEI
2013	$142.50	$142.50 x (1+0.6%) = $143.36
2014	$143.36	$143.64 x (1+0.8%) = $144.50
2015	$144.50	$144.79 x (1+0.8%) = $145.66

4. The estimated expenditures are the estimated rate multiplied the estimated visits. The annual expenditures due to MEI increase are:

(In Thousands)

	Expenditures without MEI	Expenditures with MEI	MEI Increase
2012	$1,393,913	$1,450,509	$56,595
2013	$1,500,618	$1,509,622	$9,004
2014	$1,515,294	$1,527,416	$12,122

5. For FY 2013-14, the total MEI increase includes an annualized MEI increase for year 2012 of $56,595,000 and nine months of year 2013 MEI increase of $5,065,000.

6. For FY 2014-15, the total MEI increase includes an annualized MEI increase for year 2013 of $9,004,000 and nine months of year 2014 MEI increase of $6,819,000.

(In Thousands)

FY 2013-14	**TF**	**GF**
2012 MEI Increase	$56,595	$28,298
2013 MEI Increase	$5,065	$2,533
Total	**$61,660**	**$30,831**
FY 2014-15		
2013 MEI Increase	$9,004	$4,502
2014 MEI Increase	$6,819	$3,410
Total	**$15,883**	**$7,912**

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

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HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	150
IMPLEMENTATION DATE:	10/2006
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	96

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,732,000	$12,545,000
- STATE FUNDS	$2,866,000	$6,272,500
PAYMENT LAG	0.7705	0.8912
% REFLECTED IN BASE	2.84 %	1.35 %
APPLIED TO BASE		
TOTAL FUNDS	$4,291,100	$11,029,200
STATE FUNDS	$2,145,540	$5,514,590
FEDERAL FUNDS	$2,145,540	$5,514,590

DESCRIPTION

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the Social Security Act

Interdependent Policy Changes:
Not Applicable

Background:

1. **Hospice Services**
   Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

2. **Hospice Room and Board**
   The Department ties each hospice facility's room and board rate to 95% of the individual facility's affiliated nursing facility rate and included Intermediate Care Facility – Developmentally Disabled (ICF/DDs), Intermediate Care Facility – Habilitative (ICF/DD-Hs), & Intermediate Care Facility – Nursing (ICF/DD-Ns). This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

   Pursuant to ABX4 5 (Chapter 5, Statutes of 2009), hospice room and board rates were frozen to 2008-09 levels for rate years 2009-10 and 2010-11, in those cases where the facility's per-diem rate was frozen. AB 97 (Chapter 3, Statutes of 2011) allows the Department to decide whether to implement further rate freezes for long-term care facilities (LTCs), effective June 1, 2011. The Department removed the rate freeze for certain LTCs. Hospice room and board rates will increase based on the nursing facility rate increases.

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HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150

Reason for Change from Prior Estimate:
Estimate changes are due to:

- Updated Hospice National Rates for hospice services
- 100% FY 2012-13 expenditure in Base

Methodology:

1. The estimated weighted increase for hospice service rates for FY 2013-14 and FY 2014-15 are 2.53% and 2.33% respectively.

2. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

   The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on Nursing Facility Level A and Distinct Part (DP) Nursing Facility Level B, and Freestanding Pediatric Subacute rates.

   Effective August 1, 2012, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

   The Department elected to not implement the rate freeze for all LTC facility types based on its access and utilization analyses. CMS has already approved the Department's request to not implement a rate freeze on DP Adult and Pediatric Subacute rates.

   Hospice room and board rates will continue at 95% of the facility rates, whether frozen or unfrozen.

3. The weighted increase for hospice room and board rates for FY 2013-14 and FY 2014-15 is estimated to be 3.93%.

(Dollars in Thousands)	FY 2013-14	FY 2014-15
FY 2013-14 Hospice Services	$1,563	$2,084
FY 2013-14 Room & Board	$4,168	$4,547
FY 2014-15 Hospice Services		$1,575
FY 2014-15 Room & Board		$4,339
TOTAL*	$5,732	$12,545

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

*Amounts may differ due to rounding.

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LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER:	151
IMPLEMENTATION DATE:	8/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1784

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund (GF).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)

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:
AB 1762 (Chapter 230, Statutes of 2003) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. The following LTC providers are subject to a QA fee.

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA fees collected will be deposited into the fund, rather than the state General Fund, which will be used for LTC provider reimbursement rate expenditures.

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LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 151

Reason for Change from Prior Estimate:
The change is due to the updated QA fees collection.

Methodology:
1. Based on three years of LTC QA fee collection data, the average annual LTC QA fee revenue on a cash basis is $439,445,000 and the average growth rate is 7.04%.

   Estimated QA fee revenue collected in FY 2014-15 is:
   $439,445,000 x (1+7.04%) = **$470,374,000**

(In Thousands)

	TF	GF	LTCQAF
FY 2013-14	**$0**	**($439,445)**	**$439,445**
FY 2014-15	**$0**	**($470,374)**	**$470,374**

Funding:
Long Term Care Quality Assurance Fund (4260-101-3213)
100% General Fund (4260-101-0001)

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	11/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1597

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,872,000	-$35,022,000
- STATE FUNDS	-$936,000	-$17,511,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,872,000	-$35,022,000
STATE FUNDS	-$936,000	-$17,511,000
FEDERAL FUNDS	-$936,000	-$17,511,000

DESCRIPTION

Purpose:
This policy change estimates the savings to non-AB 1629 long-term care (LTC) facilities due to the rate being frozen at 2008-09 levels for Distinct Part/Nursing Facility-Level B (DP/NF-B) and Rural Swing Bed providers.

DP Adult Subacute and DP Pediatric Subacute facilities are not subject to the rate freeze.

Nursing Facility-Level A (NF-A), Freestanding Pediatric Subacute providers, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (H) and ICF/DD-Nursing (N) provider rates are currently reimbursed at the 2008-09 rate levels and are not impacted by this policy.

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective August 1 of each year, LTC rates are re-determined annually for the following facility types: NF-A, DP/NF-B, Rural Swing Bed, DP Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, ICF-DD, ICF/DD-H, and ICF/DD-N.

ABX4 5 eliminated rate increases for these facilities effective August 1, 2009. In the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute providers, effective February 25, 2010.

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 152

Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-B.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% payment reduction and freeze at the rates established in 2008-2009, required by AB 97, with respect to DP/NF-B facilities. On December 28, 2011, the federal court issued a preliminary injunction.

On December 13, 2012, the United States Court of Appeal for the Ninth Circuit issued a decision in which it reversed the previous issued injunctions against AB 97 payment reductions and rate freezes. On January 28, 2013, the plaintiffs had requested a rehearing. On May 24, 2013, the Ninth Circuit denied the plaintiff's request for rehearing and on June 25, 2013, issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reductions and rate freezes retroactive to June 1, 2011.

The Department elected not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on their access and utilization analyses. CMS has already approved the Department's request not to implement a rate freeze on DP Adult Subacute rates. The Department has obtained the approval to not freeze DP Pediatric Subacute rate.

The Department will submit a request to CMS to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rated as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rated as required by AB 97, effective October 1, 2013.

Reason for Change from Prior Estimate:

- Delay in implementation due to pending SPA approvals and additional workload that the litigation has created for the Fiscal Intermediary.
- The June 25, 2013 court ruling formally vacated the four court injunctions and authorized the Department to implement AB 97 provisions and the Department's decision to exempt DP/NF-Bs from the rate freeze.
- Increase the total months needed to recover the retroactive savings.
- Updated rate reimbursement amounts.

Methodology:

1. The effective date of AB 97 rate freeze is June 1, 2011.

2. **Rural Swing Bed facilities**: Effective July 22, 2013, Rural Swing Bed providers are paid at the 2008-2009 level rate. Prior to this, the providers received the 2011-12 level rate. Assume the Department will recover rate freeze retroactive savings over 52 months beginning November 2013. The savings will be from June 1, 2011, through July 21, 2013.

3. **DP/NF-B facilities:** They are currently being paid at the 2011-12 level. Assume CMS approval of exempting DP/NF-B providers from the rate freeze and 10% payment reduction. Effective September 1, 2013, rural and frontier designated DP/NF-B providers will be paid at the 2013-14 level, and non-rural/frontier designated DP/NF-B providers will be paid at the 2013-14 level, effective October 1, 2013. The Department will recover rate freeze retroactive savings beginning June 24, 2014 over 66 months.

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NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 152

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

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DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	7/2012
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1185

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$4,782,000	$0
- STATE FUNDS	-$2,391,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$4,782,000	$0
STATE FUNDS	-$2,391,000	$0
FEDERAL FUNDS	-$2,391,000	$0

DESCRIPTION

Purpose:
This policy change budgets the retroactive adjustments to dental managed care rates impacting prior fiscal years.

Authority:
Welfare & Institutions Code 14301(a)

Interdependent Policy Changes:
Not Applicable

Background:
The W&I code authorizes the Department to determine the annual rate of payment for services provided for Medi-Cal beneficiaries enrolled in a prepaid health plan and to implement the new annual rates through an amendment to the contract.

In the event there is any delay in a determination of rate changes, the amendment may not be processed in time to permit payment of new rates commencing July 1. The payment to contractors shall continue at the current rates. Those continued payments shall constitute interim payments only. Upon final approval of the revised rates, the Department shall make retroactive adjustments for those months for which interim payments were made.

In August 2012, the Department terminated their contracts with one of the plans due to the plan's inability to maintain the requirements of their Knox Keene license. The Department also terminated their contracts with another plan which planned to cease operations effective June 1, 2012. The Department determined $2 million has been uncollected from the two plans.

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DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 153

Reason for Change from Prior Estimate:

The changes are due to:

- The Department terminated contracts with two dental plans and is in the process of collecting the outstanding amounts owed. The Department collected $869,000 from one plan in FY 2012-13 and is in the process of negotiating a settlement with a second plan which is estimated to be reached in the first quarter of FY 2013-14.
- Increase in monthly eligibles

Methodology:

1. Sacramento Geographic Managed Care (GMC) dental rates have changes that are retroactive to January 2012. The rates for January through December 2012 are $11.46 for those under 21 years of age and $1.45 for those 21 or over. The rates for January through December 2013 are in the process of being developed.

2. Prepaid Health Plan (PHP) dental rates have changes that are retroactive to January 2012. The rates for January through December 2012 are $11.46 for those under 21 years of age and $1.45 for those 21 or over. The rates for January through December 2013 are in the process of being developed.

3. The Program of All-Inclusive Care for the Elderly (PACE) retroactive rate adjustments are reflected in the PACE (Other M/C) policy change.

4. The Senior Care Action Network (SCAN) retroactive rate adjustments are reflected in the Senior Care Action Network policy change.

5. Beginning January 2012, the previous rates have been implemented on an ongoing basis. This policy change budgets the retroactive changes for the period from January 2012 through December 2012.

6. It is assumed that retroactive adjustments for the period of January 2012 through December 2012 will be completed in FY 2013-14.

7. Currently, all dental plans except Liberty Dental Plan of California are being paid the current 2012 rates.

8. Assume the Department will receive the outstanding balances owed from the one plan in FY 2013-14.

9. There are an estimated $500,000 remaining of outstanding invoices to be collected FY 2013-14.

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DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 153

		Existing Rate	New Rate	Change	Eligible Months	Dental Retro Rate Adjustment
GMC 2012	Jan-Dec					
	<21	$11.83	$11.46	($0.37)	1,676,336	($620,000)
	21+	$2.91	$1.45	($1.46)	913,874	($1,334,000)
PHP 2012	Jan-Dec					
	<21	$11.83	$11.46	($0.37)	2,550,957	($944,000)
	21+	$2.91	$1.45	($1.46)	947,128	($1,383,000)
Total FY 2013-14 Dental Retroactive Adjustments						($4,281,000)
Total FY 2013-14 Outstanding invoices						($500,000)
Total FY 2013-14						**($4,782,000)**
Total GF FY 2013-14						**($2,391,000)**

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

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LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	154
IMPLEMENTATION DATE:	11/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1703

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$9,850,000	-$14,775,000
- STATE FUNDS	-$4,925,000	-$7,387,500
PAYMENT LAG	0.8607	0.9960
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$8,477,900	-$14,715,900
STATE FUNDS	-$4,238,950	-$7,357,950
FEDERAL FUNDS	-$4,238,950	-$7,357,950

DESCRIPTION

Purpose:
This policy change estimates savings related to a clinical laboratory reimbursement reduction of up to 10%, and the savings from a new clinical laboratory reimbursement methodology.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 allows the Department to develop a new rate methodology for clinical laboratory and laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2012), AB 1494 allows payments to be reduced by 10% for clinical lab services for dates of service on and after July 1, 2012. The 10% payment reduction pursuant to AB 1494 shall continue until the new rate methodology has been approved by the Centers for Medicare and Medicaid Services (CMS). The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.

Reason for Change from Prior Estimate:
The changes are due to delay in expected federal approval:
- Implementation date for the new lab rate methodology has changed from October 2013 to April 2014.
- Implementation date for the 10% payment reduction has changed from July 2013 to October 2013.

Methodology:
1. Assume savings will begin upon CMS approval and the subsequent CA-MMIS system implementation. The system implementation for the 10% payment reduction is anticipated to take place in November of 2013. The retroactive date for the 10% payment reduction is July 1, 2012.

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 154

2. The new laboratory rate methodology will be implemented on April 1, 2014.

3. The projected weighted average savings for the new lab rate methodology is 10%.

4. The 10% reduction will be assessed after the AB 97 (Chapter 3, Statutes of 2011) 10% reduction.

5. Annual savings are projected at $9,850,000 TF.

6. The total recoupment of the retroactive savings from July 1, 2012 to October 31, 2013, is estimated to be $13,133,000 TF and is expected to be recovered over 32 months beginning November 2013.

7. Savings in FY 2013-14 will consist of three months of the new lab rate methodology, five months of the 10% payment reduction savings, and eight months of retroactive savings.

8. Savings in FY 2014-15 will consist of 12 months of the new lab rate methodology and 12 months of retroactive savings.

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
2013-14 Savings	$6,567	$3,283	$3,283
Retroactive Savings	$3,283	$1,642	$1,642
Total*	**$9,850**	**$4,925**	**$4,925**

FY 2014-15	**TF**	**GF**	**FF**
2014-15 Savings	$9,850	$4,925	$4,925
Retroactive Savings	$4,925	$2,463	$2,463
Total*	**$14,775**	**$7,388**	**$7,388**

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

*Amounts may differ due to rounding.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER:	155
IMPLEMENTATION DATE:	5/2012
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1579

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$13,035,000	-$34,256,000
- STATE FUNDS	-$6,517,500	-$17,128,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	2.89 %	0.80 %
APPLIED TO BASE		
TOTAL FUNDS	-$12,658,300	-$33,982,000
STATE FUNDS	-$6,329,140	-$16,990,980
FEDERAL FUNDS	-$6,329,140	-$16,990,980

DESCRIPTION

Purpose:
This policy change estimates the savings due to the implementation of provider payment reductions applied to nursing and subacute facilities reimbursed under AB 1629 (Chapter 875, Statutes of 2004) reimbursement methodology, Nursing Facility - A (NF-A), Distinct Part Nursing Facility - B (DP/NF-B), Freestanding (FS) Adult Subacute Facility, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD - Nursing (N), and ICF/DD - Habilitative (H) providers based on AB 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statues of 2013)

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:
Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers.

Effective June 1, 2011, AB 97 required the Department to reduce payments to long-term care facilities by up to 10% in FFS and the actuarially equivalent of that amount in managed care. However, ABX1 19 required the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% below rate year 2008-09 rates. Additionally, under ABX1 19, the 10% payment reduction for AB 1629 facilities ended on July 31, 2012. The Department did not implement the 5.57% payment reduction for the

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 155

Freestanding Pediatric Subacute facilities, because it determined access would be compromised.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers, effective August 1, 2012. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97. On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunction. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.

Due to access concern, the Department will submit a request to CMS to exempt:

- DP/NF-B providers located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B providers from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective October 1, 2013.

The actuarial equivalent of FFS payment reductions to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

Reason for Change from Prior Estimate:

- This policy change now includes the erosion of savings related to AB 97 injunction, which was previously budgeted in the AB Injunction policy change. The injunctions were lifted on June 25, 2013.
- Delay in implementation of payment reductions due to pending State Plan Amendment (SPA) approvals, ongoing litigation, and workload issues that the litigation has created for the Fiscal Intermediary.
- Updated program expenditures.
- Exemption of DP/NF-B providers from payment reductions.
- Forgive AB 97 retroactive recoupment for ICF DDs.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013.

2. **FFS:** The Department implements the FFS payment reduction in various phases.
   - **AB 1629 Facilities:** This phase includes FS NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.

   - **ICF/DDs:** This phase includes ICF/DD, ICF/DD-N, and ICF/DD-H providers.

   - **DP/NF-Bs:** These are the previously enjoined providers.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 155

3. Due to access concerns, the Department will forgo the retroactive recoupment for ICF DDs.

Facility Type	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
ICF/DDs	11/1/2013	N/A	N/A	N/A
NF-As	7/1/2012	13	9/1/2012	24
	Payment Reduction Exempt Effective Date			
DP/NF-Bs				
Rural & Frontier	9/1/2013	27	7/1/2014	66
Non Rural & Frontier	10/1/2013	28	7/1/2014	66

4. It is estimated that the Department will recoup FFS retroactive savings of $123,000 TF in FY 2013-14 and $15,190,000 TF in FY 2014-15.

		FY 2013-14	Total Fund FY 2014-15	Annual
AB 1629 Facilities	FFS	$0	$0	$0
ICF/DDs	FFS	($11,603,000)	($17,405,000)	($17,405,000)
NF-As	FFS	($254,000)	($254,000)	($254,000)
	FFS Retro	($123,000)	($20,000)	($123,000)
	NF-As Total	($377,000)	($274,000)	
DP/NF-Bs	FFS	$0	$0	$0
	FFS Retro	$0	($15,170,000)	($15,170,000)
	DP/NF-Bs Total	$0	($15,170,000)	
	Total FFS	($11,857,000)	($17,659,000)	($17,659,000)
	Total FFS Retro	($123,000)	($15,190,000)	($15,293,000)
	Total Managed Care	($1,055,000)	($1,407,000)	($1,407,000)
Grand Total		**($13,035,000)**	**($34,256,000)**	

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

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REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	12/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1505

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$35,474,000	-$60,813,000
- STATE FUNDS	-$17,737,000	-$30,406,500
PAYMENT LAG	0.8073	0.9932
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$28,638,200	-$60,399,500
STATE FUNDS	-$14,319,080	-$30,199,740
FEDERAL FUNDS	-$14,319,080	-$30,199,740

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of a reduction to radiology rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rates with dates of service on or after October 1, 2010. Radiology rates in excess of this amount will be reduced. Due to delay in expected federal approval, a two-year retroactive application of this reduction could adversely impact access to needed radiology services. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% reduction, and that federal approval of a reduction with a lengthy retroactive recoupment is extremely unlikely, the effective date for retroactive savings shifted from October 1, 2010 to July 1, 2012.

Reason for Change from Prior Estimate:
The Department changed the implementation date from May 2013 to December 2013 because of delay in expected federal approval.

Methodology:
1. Implementation will begin in December 2013.

2. Rate reductions will be retroactive to July 1, 2012.

3. The rate reductions will apply to radiology services that are paid at reimbursement rates exceeding 80% of Medicare rates. The weighted average reduction for rates above 80% of Medicare is 18%.

4. Based on 2010 Medi-Cal payment rate data, the rate reductions will result in an annual fee-for-

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 156

service (FFS) savings of $39,633,000. The 2010 Medi-Cal payment rate includes a 1% reduction to radiology services as required by AB 1183 (Chapter 758, Statutes of 2008).

FFS Monthly Savings:
$39, 633,000 ÷ 12 months = $3,303,000

5. There is no managed care impact as a result of this reduction because managed care capitation rates are calculated using radiology rates that are at or below 80% of Medicare rates.

6. The total recoupment of retroactive savings from July 1, 2012 to November 30, 2013, is estimated to be $56,146,551 and is expected to occur over 31.81 months beginning December 2013.

Total recoupment of retroactive savings:
$39, 633,000 ÷ 12 months x 17 months = $56,146,551
Monthly recoupment amount is $1,765,072

(Dollars In Thousands)

FY 2013-14	**TF**	**GF**	**FF**
2013-14 Savings	($23,119)	($11,560)	($11,560)
Recoupment of Retro Savings	($12,356)	($6,178)	($6,178)
Total*	**($35,475)**	**($17,737)**	**($17,737)**

FY 2014-15	**TF**	**GF**	**FF**
2014-15 Savings	($39,633)	($19,816)	($19,816)
Recoupment of Retro Savings	($21,181)	($10,590)	($10,590)
Total*	**($60,814)**	**($30,407)**	**($30,407)**

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

*Amounts may differ due to rounding.

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10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	157
IMPLEMENTATION DATE:	12/2011
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1580

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$312,677,000	-$531,384,000
- STATE FUNDS	-$156,338,500	-$265,692,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	25.16 %	12.10 %
APPLIED TO BASE		
TOTAL FUNDS	-$234,007,500	-$467,086,500
STATE FUNDS	-$117,003,730	-$233,543,270
FEDERAL FUNDS	-$117,003,730	-$233,543,270

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of the provider payment reduction pursuant to Assembly Bill (AB) 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)

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:
AB 97 requires the Department to implement up to a 10% provider payment reduction, which will affect all services except:

- Hospital inpatient and outpatient services, critical access hospital, federal rural referral centers,
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs),
- Services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs,
- Hospice services,
- Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services, and
- Payments funded by certified public expenditures and intergovernmental transfers.

Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5%. Other fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. A recent court decision vacated the preliminary injunctions clearing the way for the

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157

Department to implement the payment reductions. The FFS payment reductions will be retroactive to June 1, 2011. For the court actions related to the implementation of AB 97, see the AB 97 Injunctions policy change.

The actuarial equivalent of FFS payment reductions to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

Reason for Change from Prior Estimate:

- This policy change now includes the erosion of savings related to AB 97 injunction, which was previously budgeted in the AB 97 Injunction policy change. The injunction was lifted on June 25, 2013.
- Delay in implementation of payment reductions due to ongoing litigation and workload issues that the litigation has created for the Fiscal Intermediary.
- Updated program expenditures.
- Additional providers and services are exempted from the payment reduction.
- Forgive retroactive recoupments for specified providers.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013. The following services will not be subject to a reduction:
   - Pharmacy, and
   - Specialty physician services.

2. **FFS**: The Department implements the FFS payment reductions in three phases.

   - **Phase I**: Phase I includes all subject providers except for the previously enjoined providers and the Child Health and Disability Prevention (CHDP) program.

     - Pediatric Day Health Care (PDHC) program are exempt from the 10% payment reduction effective April 1, 2012. The Department stopped the 10% payment reduction on October 25, 2012. The refund for reduced payment for services on or after April 1, 2012 was installed in July 2013.
     - The Department proposes to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012. The Department anticipates stopping the 10% payment reduction in January 2014 and refunding the payment reduction for the period June 1, 2011 through December 31, 2013 in April 2014.
     - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and anticipates refunding the payment reduction for the period June 1, 2011 through August 31, 2013 in November 2013.
     - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department will stop the 10% payment reduction in December 2013 and anticipates refunding the payment reduction for the period June 1, 2011 through November 30, 2013 in September 2014.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157

- **Phase II**: Phase II includes all the previously enjoined providers.
  - o Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 will be exempt from the 10% payment reduction effective September 1, 2013.
  - o For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 will be exempt from the 10% payment reduction effective December 1, 2013, pending the federal approval.
  - o Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions will be exempt from the 10% payment reduction effective March 31, 2012.

- **Phase III**: Phase III includes the CHDP program providers.

3. Due to access concerns, the Department will forgo the retroactive recoupments for the following providers:
   - Physicians,
   - Medical transportation,
   - Dental,
   - Clinics,
   - Certain high-cost drugs, and
   - CHDP.

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	6/1/2011	1/10/2014	N/A	N/A	N/A
Medical Transportation	6/1/2011	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	4/22/2014	63
Dental	6/1/2011	9/5/2013	N/A	N/A	N/A
Clinics	6/1/2011	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	7/1/2014	66
Phase III (CHDP)	6/1/2011	11/1/2013	N/A	N/A	N/A

4. It is estimated that the Department will recoup FFS retroactive savings of $15,628,000 TF in FY 2013-14 and $61,441,000 TF in FY 2014-15.

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10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157

(Dollars In Thousands)		Total Fund FY 2013-14	FY 2014-15	Annual
Phase I	FFS	($55,209)	($56,137)	($61,951)
	FFS Retro	($14,377)	$0	($14,377)
	Phase I Total	($69,586)	($56,137)	
Phase II				
Physicians	FFS	($24,873)	($49,746)	($49,746)
Medical Transportation	FFS	($12,051)	($14,461)	($14,461)
DME/Medical Supplies	FFS	($11,596)	($17,394)	($17,394)
	FFS Retro	($1,252)	($7,510)	($7,510)
Dental	FFS	($35,451)	($64,734)	($64,734)
Clinics	FFS	($9,256)	($18,512)	($18,512)
Pharmacy	FFS	($47,382)	($113,718)	($113,718)
	FFS Retro	$0	($53,931)	($53,931)
	FFS	($140,610)	($278,565)	($278,565)
	FFS Retro	($1,252)	($61,441)	($61,441)
	Phase II Total	($283,723)	($680,012)	
Phase III (CHDP)	FFS	($1,609)	($2,414)	($2,414)
	FFS	($197,428)	($337,116)	($342,930)
	FFS Retro	($15,628)	($61,441)	($75,818)
	Managed Care	($99,621)	($132,827)	($132,827)
	Grand Total	**($312,677)**	**($531,384)**	

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

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HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	158
IMPLEMENTATION DATE:	9/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1475

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,209,680,000	$0
- STATE FUNDS	$2,114,955,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,209,680,000	$0
STATE FUNDS	$2,114,955,000	$0
FEDERAL FUNDS	$2,094,725,000	$0

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the quality assurance fee (QAF) program.

Authority:
AB 1383 (Chapter 627, Statutes of 2009)
AB 188 (Chapter 645, Statutes of 2009)
AB 1653 (Chapter 218, Statutes of 2010)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)

Interdependent Policy Changes:
PC 134 Extend Gross Premium Tax
PC 121 Extend Gross Premium Tax – Incr. Capitation Rates
PC 137 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:
AB 1383 authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 158

AB 188 (Chapter 645, Statues of 2009) established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 extended the Hospital QAF program for the period January 1, 2011 through June 30, 2011 based on a modified amount of payments to hospitals and an increased amount for children's health care coverage.

SB 335 extended the Hospital QAF program from July 1, 2011 through December 31, 2013. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SB 920:

- Modified the QAF calculation and installment payment provisions, supplemental amounts paid to private hospitals for inpatient services,
- Increased the NDPH aggregate grant amounts for each fiscal year, and
- Reduced the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund, and deleted NDPHs as recipients of money from the fund.

Reason for Change from Prior Estimate:

The changes are due to:

- Inclusion of QAF I mental health plan payments,
- Updated QAF II payments, and
- Revised QAF III fee collection less than previously scheduled.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The first QAF program was effective April 1, 2009 through December 31, 2010 (QAF I); with a two-quarter extension through June 30, 2011 (QAF II). An additional 30-month QAF program is effective for the time period July 1, 2011 through December 31, 2013 (QAF III).

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 158

3. On an accrual basis, the QAF III program fee is expected to generate $4.3 billion in FY 2011-12, $4.5 billion in FY 2012-13, and $2.4 billion in FY 2013-14 in fee-for-service (FFS), managed care capitation, grant payments and mental health payments.

4. First FFS payment of the QAF III program to the hospitals occurred in August 2012.

5. $29 million of the QAF I program mental health plan payments will be paid in FY 2013-14.

6. $1.2 million of the QAF II program FFS payments will be paid in FY 2013-14.

7. On a cash basis, payments to the hospitals are estimated to be:

FY 2013-14	TF	SF(HQARF)	FF	ARRA
AB 1383**	$29,376,000	$11,283,000	$14,688,000	$3,405,000
SB 90*	$1,217,000	$525,000	$609,000	$84,000
SB 335**	$4,179,087,000	$2,103,147,000	$2,075,940,000	
Total	**$4,209,680,000**	**$2,114,955,000**	**$2,091,237,000**	**$3,489,000**

Totals may differ due to rounding.

Funding:
Hospital Quality Assurance Revenue Fund (4260-610-3158)*
Hospital Quality Assurance Revenue Fund (4260-611-3158)**
Title XIX FFP (4260-101-0890)

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EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	4/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1761

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,261,177,000	$7,024,244,000
- STATE FUNDS	$1,137,338,000	$3,539,684,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,261,177,000	$7,024,244,000
STATE FUNDS	$1,137,338,000	$3,539,684,000
FEDERAL FUNDS	$1,123,839,000	$3,484,560,000

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the extension of quality assurance fee (QAF) program.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

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:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014 through December 31, 2016.

Reason for Change from Prior Estimate:
The changes are due to the updated fee model.

Methodology:
1. The current Hospital QAF program will end on December 31, 2013. Assume a 36-month extension for the Hospital QAF program beginning January 1, 2014 through December 31, 2016.

2. The first Fee-For-Service (FFS) payment is estimated to be made in April 2014. This includes designated public hospital and non-designated public hospital grant amounts.

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159

3. The first managed care payment is estimated to be made in May 2014.

4. On a cash basis, the estimated QAF payments are:

(Dollars In Thousands)	TF	SF(HQARF)	FF
FY 2013-14	**$2,261,177**	**$1,137,338**	**$1,123,839**
FY 2014-15	**$7,024,244**	**$3,539,684**	**$3,484,560**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-101-0890)

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	160
IMPLEMENTATION DATE:	10/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1140

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$455,989,000	$66,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$455,989,000	$66,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$455,989,000	$66,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to freestanding, non-hospital based clinics.

Authority:
AB 959 (Chapter 162, Statutes of 2006), Welfare & Institutions Code 14105.965

Interdependent Policy Change:
Not Applicable

Background:
Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down federal financial participation (FFP) is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities.

The State Plan Amendment (SPA) for this program was approved on August 8, 2012. Supplemental payments to freestanding, non-hospital based clinics will be retroactive to October 14, 2006. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the completion of audited cost reports.

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

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 160

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

2. Supplemental payments for freestanding, non-hospital based clinics are expected to begin October 2013.

3. Annual supplemental payments to freestanding, non-hospital based clinics are expected to total between $60,000,000 and $75,000,000.

4. Supplemental payments are paid after the completion of cost report audits.

Program payment amounts are estimated to be:

(Dollars in Thousands)

FY 2013-14	**TF**	**ARRA**	**FFP**
FY 2006-07	$60,000		$60,000
FY 2007-08	$60,000		$60,000
FY 2008-09	$63,000	$5,928	$57,072
FY 2009-10	$66,000	$12,420	$53,580
FY 2010-11	$74,989	$12,094	$62,895
FY 2011-12	$66,000		$66,000
FY 2012-13	$66,000		$66,000
Total FY 2013-14	**$455,989**	**$30,442**	**$425,547**

(Dollars in Thousands)

FY 2014-15	**TF**	**ARRA**	**FFP**
FY 2013-14	**$66,000**	$0	**$66,000**

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

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	1/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1661

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$190,500,000	$50,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$190,500,000	$50,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$190,500,000	$50,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:
AB 678 (Chapter 397, Statutes of 2011)

Interdependent Policy Changes
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) on September 4, 2013. Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

Reason for Change from Prior Estimate:
The change is due to:

- A delay in CMS approval for the SPA, and
- Updated program expenditures.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. Funding for services provided between January 30, 2010 through June 30, 2011 will be reimbursed at the appropriate FMAP rate.

3. Payments will begin in January 2014.

The estimated payments on a cash basis are:

(Dollars In Thousands)

FY 2013-14		CPE	Regular FFP	ARRA	Total FFP
	FY 2009-10	$50,000	$25,000	$5,800	$30,800
	FY 2010-11	$100,000	$50,000	$9,700	$59,700
	FY 2011-12	$100,000	$50,000	$0	$50,000
	FY 2012-13	$100,000	$50,000	$0	$50,000
Total		$350,000	$175,000	$15,500	**$190,500**

FY 2014-15		CPE	Regular FFP	ARRA	Total FFP
Total	FY 2013-14	$100,000	$50,000	$0	**$50,000**

Funding:

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

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HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	162
IMPLEMENTATION DATE:	4/2004
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	78

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$179,174,000	$186,774,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$179,174,000	$186,774,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$179,174,000	$186,774,000

DESCRIPTION

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal beneficiaries.

Authority:
AB 915 (Chapter 747, Statutes of 2002)

Interdependent Policy Changes:
Not Applicable

Background:
AB 915 created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Publicly owned or operated hospitals now receive supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

Reason for Change from Prior Estimate:
The changes are due to:

- Payments scheduled to be paid in FY 2012-13 are delayed to FY 2013-14, and
- Revised caseload amounts for FY 2013-14.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level. The Department will apply the appropriate FMAP to the reconciliation.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 162

2. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2013-14. Additional payments of $9,385,000 for service year 2002-03 are expected to be made in FY 2013-14 as a result of the reconciliation.

3. Payments of $169,789,000 are expected to be made in FY 2013-14 based on CPE claims for FY 2002-03 through FY 2012-13. The FY 2002-03 Reconciliation payment noted in Methodology #2 is not included in this amount. Payments are adjusted for the change in the FMAP.

4. The reconciliation for FY 2003-04 is expected to be completed in FY 2014-15. Additional payments of $9,400,000 are expected to be made as a result of the reconciliation.

5. Payments of $177,374,000 are expected to be made in FY 2014-15 based on CPE claims.

Estimated costs are as follows:

		FY 2013-14	
	Regular FFP	**ARRA**	**Total FFP**
FY 2002-03 (Reconciliation)	$9,385,000		$9,385,000
FY 2002-03	$921,000		$921,000
FY 2009-10	$754,000	$175,000	$929,000
FY 2010-11	$1,002,000	$195,000	$1,197,000
FY 2011-12	$2,254,000		$2,254,000
FY 2012-13	$164,488,000		$164,488,000
	$178,804,000	$370,000	**$179,174,000**

		FY 2014-15	
	Regular FFP	**ARRA**	**Total FFP**
FY 2003-04 (Reconciliation)	$9,400,000		$9,400,000
FY 2011-12	$830,000		$830,000
FY 2012-13	$2,384,000		$2,384,000
FY 2013-14	$174,160,000		$174,160,000
	$186,774,000	$0	**$186,774,000**

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

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NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	163
IMPLEMENTATION DATE:	10/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1600

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$140,000,000	$70,000,000
- STATE FUNDS	$70,000,000	$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$140,000,000	$70,000,000
STATE FUNDS	$70,000,000	$35,000,000
FEDERAL FUNDS	$70,000,000	$35,000,000

DESCRIPTION

Purpose:
This policy change estimates the revenue and payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:
AB 113 (Chapter 20, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset GF costs of Medi-Cal children's health services.

AB 1467 (Chapter 23, Statutes of 2012) changed the NDPH reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. The Department submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), which was later withdrawn by the Department.

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

Methodology:
1. The estimated NDPH IGT supplemental payments are:

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NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 163

(Dollars in Thousands)

FY 2013-14	TF	GF**	IGT*	FF
FY 2012-13 Payments to NDPHs	$70,000	$0	$35,000	$35,000
FY 2012-13 Children's Services	$0	($3,322)	$3,322	$0
FY 2013-14 Payments to NDPHs	$70,000	$0	$35,000	$35,000
FY 2013-14 Children's Services	$0	($3,322)	$3,322	$0
Total	**$140,000**	**($6,644)**	**$76,644**	**$70,000**
FY 2014-15				
Payments to NDPHs	$70,000	$0	$35,000	$35,000
Children's Services	$0	($3,322)	$3,322	$0
Total	**$70,000**	**($3,322)**	**$38,322**	**$35,000**

Funding:
50% Medi-Cal Inpatient Payment Adjustment (MIPA) Fund (4260-606-0834)*
50% Title XIX FF (4260-101-0890)*
100% GF (4260-101-0001)**

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CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER:	164
IMPLEMENTATION DATE:	6/2002
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	86

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$117,889,000	$43,658,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$117,889,000	$43,658,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$117,889,000	$43,658,000

DESCRIPTION

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals.

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

Interdependent Policy Changes:
Not Applicable

Background:
This program is designed to allow DP-NFs to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays under the existing program. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal Beneficiaries.

Reason for Change from Prior Estimate:
The change is due to:

- A delay of FY 2012-13 payments to be disbursed in FY 2013-14,
- The addition of FY 2006-07, FY 2009-10, and AB 97 related adjustment payments to be disbursed in FY 2013-14,
- A delay of the FY 2009-10 Reconciliation and FY 2013-14 payments to be disbursed in FY 2014-15.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 164

through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2013-14 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

3. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Interim payments, or recoupment of overpaid funds, are expected during the current fiscal year (represented below).

4. AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reduce Medi-Cal provider payments for services DP-NF Level B providers rendered on or after June 1, 2011. Proposed legislation states DP/NF Level B providers are exempt from AB 97 reductions beginning October 1, 2013. Expenditures related to AB 97 adjustments will be made in FY 2013-14.

5. Payments are not made through the fiscal intermediary; consequently, they are not reflected in the Medi-Cal base trend data and must be budgeted in this policy change.

6. Based on a funding of historical data and AB 97 rate reduction calculations, an estimate of $117,889,000 FFP and $43,658,000 FFP will be available in FY 2013-14 and FY 2014-15, respectively.

FY 2013-14	**Total FFP**	**FFP**	**ARRA**
FY 2006-07	$34,000	$34,000	
FY 2008-09 Reconciliation	$2,113,000	$1,800,000	$313,000
FY 2009-10	$5,314,000	$4,314,000	$1,000,000
FY 2012-13	$39,047,000	$39,047,000	
AB 97 Adjustments			
FY 2010-11	$19,789,000	$18,615,000	$1,174,000
FY 2011-12	$51,592,000	$51,592,000	
Total FY 2013-14	**$117,889,000**	$115,402,000	$2,487,000

FY 2014-15	**Total FFP**	**FFP**	**ARRA**
FY 2009-10 Reconciliation	$2,420,000	$1,964,000	$456,000
FY 2013-14	$41,238,000	$41,238,000	
Total FY 2014-15	**$43,658,000**	$43,202,000	$456,000

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

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CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	165
IMPLEMENTATION DATE:	7/1991
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	82

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$117,187,000	$110,857,000
- STATE FUNDS	$48,689,500	$45,211,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$117,187,000	$110,857,000
STATE FUNDS	$48,689,500	$45,211,000
FEDERAL FUNDS	$68,497,500	$65,646,000

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:
SB 1732 (Chapter 1635, Statutes of 1988)
SB 2665 (Chapter 1310, Statutes of 1990)
SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ends June 30, 2013 due to the implementation of the Diagnosis Related Group payment methodology. A State Plan Amendment (SPA) will be required to maintain the Federal authority for SB 1732. The SPA is pending final review from CMS. The Department expects the Center for Medicare and Medicaid Services will approve the SPA by December 2013.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code.

Reason for Change from Prior Estimate:
FY 2013-14 payments increase due to a reconciliation of interim payments and adjustments to the provider bond payment schedules.

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CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 165

Methodology:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FFP**
Hospitals	$97,379	$48,689	$48,690
DP-NFs	$19,808	$0	$19,808
Total*	**$117,187**	**$48,689**	**$68,497**

FY 2014-15	**TF**	**GF**	**FFP**
Hospitals	$90,422	$45,211	$45,211
DP-NFs	$20,435	$0	$20,435
Total	**$110,857**	**$45,211**	**$65,646**

Funding:

100% Title XIX (4260-101-0890)

50% GF / 50% Title XIX Capital Debt FFP (4260-102-0001/0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	2/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	104

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$70,000,000
- STATE FUNDS	$50,000,000	$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$70,000,000
STATE FUNDS	$50,000,000	$35,000,000
FEDERAL FUNDS	$50,000,000	$35,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
This program allows Los Angeles and Alameda Counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:
Payments previously scheduled to be made in FY 2013-14 were adjusted to incorporate updated payment figures to include additional payments linked to FY 2013-14.

Methodology:
1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

(Dollars in Thousands)

FY 2013-14	TF	Special Deposit Fund	FFP
FY 2012-13	$30,000	$15,000	$15,000
FY 2013-14	$70,000	$35,000	$35,000
Total FY 2013-14	**$100,000**	**$50,000**	**$50,000**

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FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 166

(Dollars in Thousands)

FY 2014-15	TF	Special Deposit Fund	FFP
FY 2014-15	$70,000	$35,000	$35,000
Total FY 2014-15	**$70,000**	**$35,000**	**$35,000**

Funding Table:
50% Local Trauma Centers Fund / 50% Title XIX FFP (4260-601-0942142) / (4260-101-0890)

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IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	7/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1158

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$15,000,000	$15,000,000
- STATE FUNDS	$7,500,000	$7,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$15,000,000	$15,000,000
STATE FUNDS	$7,500,000	$7,500,000
FEDERAL FUNDS	$7,500,000	$7,500,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to non-SB 1100 hospitals.

Authority:
Welfare & Institutions Code 14164

Interdependent Policy Changes
Not Applicable

Background:
The Welfare & Institutions Code provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program.

This policy change provides authority to accept the IGTs from counties or health care districts, match them with federal funds, and distribute the funds to hospitals designated by the counties or health care districts for the purpose of supporting hospitals serving Medi-Cal beneficiaries.

This policy change is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under the Welfare & Institutions Code, section 14166.12.

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

Methodology:
1. Annual IGTs on an accrual basis are estimated to be $15,000,000. Cash basis payments vary from year-to-year based on when the IGTs are actually received.

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IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 167

(Dollars In Thousands)	TF	IGT	FFP
FY 2013-14	**$15,000**	**$7,500**	**$7,500**

	TF	IGT	FFP
FY 2014-15	**$15,000**	**$7,500**	**$7,500**

Funding:
50% Reimbursement GF / 50% Title XIX (4260-610-0995 / 4260-101-0890)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	1/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1038

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

2.

(Dollars in Thousands)

	TF	FF	GF
FY 2013-14	**$10,000**	**$5,000**	**$5,000**
FY 2014-15	**$10,000**	**$5,000**	**$5,000**

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MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 168

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	1/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1039

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides SRHs with increased reimbursement rates. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

(Dollars in Thousands)

	TF	FF	GF
FY 2013-14	**$8,000**	**$4,000**	**$4,000**
FY 2014-15	**$8,000**	**$4,000**	**$4,000**

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 169

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

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STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	170
IMPLEMENTATION DATE:	12/2010
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1616

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,475,000	$3,800,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,475,000	$3,800,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$5,475,000	$3,800,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)

Interdependent Policy Changes:
Not Applicable

Background:
Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. The Department certifies expenditures reported in facilities' cost report before claiming FFP.

Reasons for Change from Prior Estimate:
A portion of supplemental payments previously scheduled to be made in FY 2012-13 will be made in FY 2013-14.

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

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STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

Program payment amounts are estimated to be:

(In Thousands)

FY 2013-14	**FFP**
State Veterans' Homes for FY 2012-13	$3,600
State Veterans' Homes for FY 2013-14	$1,875
Total	**$5,475**

FY 2014-15	
State Veterans' Homes for FY 2013-14	$1,875
State Veterans' Homes for FY 2014-15	$1,925
Total	**$3,800**

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1488

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$240,434,000	$151,719,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$240,434,000	$151,719,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$240,434,000	$151,719,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade (AIU) and meaningfully use (MU) Electronic Health records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:
ARRA of 2009
SB 945 (Chapter 433, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The HITECH Act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must AIU and MU certified EHR technology in accordance with the HITECH Act. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department plans to expand the current Medicaid Management Information Systems (MMIS) to integrate a State Level Registry (SLR) payment functionality, allowing for more seamless and efficient participation and payment for eligible providers. The payments are intended to accelerate AIU and encourage MU of the EHR technology by providers serving the Medi-Cal population. It is estimated that approximately 20,000 to 22,000 providers, and 400 hospitals, will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal financial participation (FFP).

The Medi-Cal Fiscal Intermediary (FI) has implemented a system necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive Program. System costs

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 177

are budgeted in the FI Estimate. Administrative costs for the State's Health Information Technology (HIT) program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Reason for Change from Prior Estimate:
The expected incentive payment costs to providers have been adjusted and are based on actual expenditures.

Methodology:

1. Payments to the providers began in December 2011.

2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.

3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is $21,250. Incentive payments for years two through six are $8,500 per eligible year. The maximum incentive payment for a professional over the six year period is $63,750.

4. Assume the aggregate hospital incentive payment amount is computed on a $2,000,000 base amount adjusted up or down depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. The years do not have to be consecutive. Payments will be limited to 50% of the aggregate hospital incentive payment for the first eligibility year, 30% for the second eligibility year and 10% for the third and fourth payment eligibility years.

5. Assume for FY 2013-14 and FY 2014-15, the aggregate hospital incentive payment is $3,100,000. The first year eligibility incentive payment will average $1,550,000, the second year eligible incentive payment will average $930,000, and the third and fourth year eligibility incentive payments will average $310,000.

6. In FY 2013-14, assume 3,026 eligible professionals will receive a first year eligibility incentive payment, 2,795 eligible professionals will receive a second year eligibility incentive payment, and 384 eligible professionals will receive a third year eligibility incentive payment. Of the eligible hospitals, 12 will receive a first year eligibility incentive payment, 124 will receive a second year eligibility incentive payment, and 49 will receive a third year eligibility incentive payment in FY 2013-14.

   3,026 professionals x $21,250 = $64,302,500
   2,795 professionals x $8,500 = $23,757,500
   384 professionals x $8,500 = $3,264,000

   12 hospitals x $1,550,000 = $18,600,000
   124 hospitals x $930,000 = $115,320,000
   49 hospitals x $310,000 = $15,190,000

7. In FY 2014-15, assume 2,057 eligible professionals will receive a first year eligibility incentive payment, 2,869 eligible professionals will receive a second year eligibility incentive payment, and 866 eligible professionals will receive a third year eligibility incentive payment. Of the eligible hospitals, 5 will receive a first year eligibility incentive payment, 40 will receive a second

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 177

year eligibility incentive payment, and 101 will receive a third year eligibility incentive payment in FY 2014-15.

2,057 professionals x $21,250 = $43,711,250
2,869 professionals x $8,500 = $24,386,500
866 professionals x $8,500 = $7,361,000

5 hospitals x $1,550,000 = $7,750,000
40 hospitals x $930,000 = $37,200,000
101 hospitals x $310,000 = $31,310,000

CASH BASIS	**FF**
FY 2013-14	
Eligibility Year 1 Professional Payments	$64,302,500
Eligibility Year 2 Professional Payments	$23,757,500
Eligibility Year 3 Professional Payments	$3,264,000
Eligibility Year 1 Hospital Payments	$18,600,000
Eligibility Year 2 Hospital Payments	$115,320,000
Eligibility Year 3 Hospital Payments	$15,190,000
	$240,434,000
FY 2014-15	
Eligibility Year 1 Professional Payments	$43,711,250
Eligibility Year 2 Professional Payments	$24,386,500
Eligibility Year 3-4 Professional Payments	$7,361,000
Eligibility Year 1 Hospital Payments	$7,750,000
Eligibility Year 2 Hospital Payments	$37,200,000
Eligibility Year 3-4 Hospital Payments	$31,310,000
	$151,718,750

Funding:
100% FFP (4260-101-0001)

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ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	6/2011
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1232

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$133,245,000	$88,060,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$133,245,000	$88,060,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$133,245,000	$88,060,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries for the California Department of Developmental Services (CDDS).

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD beneficiaries. CMS approved reimbursement for these costs retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2013-14 and FY 2014-15. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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 expenditures reflects that prior year billings and ARRA payments will be complete before FY 2014-15.

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ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 178

Methodology:
The following estimates have been provided by CDDS:

(In Thousands)

CASH BASIS	TF	CDDS GF	FFP Regular	FFP ARRA	Total* FFP	IA #
FY 2013-14	$254,998	$121,754	$127,499	$5,745	**$133,245**	07-65896
FY 2014-15	$172,289	$84,229	$86,145	$1,915	**$88,060**	07-65896

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

*Amounts may differ due to rounding.

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NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	183
IMPLEMENTATION DATE:	7/2008
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1340

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,487,000	$8,501,000
- STATE FUNDS	$5,743,500	$4,250,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,487,000	$8,501,000
STATE FUNDS	$5,743,500	$4,250,500
FEDERAL FUNDS	$5,743,500	$4,250,500

DESCRIPTION

Purpose:
This policy change estimates the noncontract hospital inpatient cost settlements.

Authority:
Welfare & Institutions (W&I) Code 14170

Interdependent Policy Changes:
Not Applicable

Background:
All noncontract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the noncontract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.

Beginning July 1, 2013, with the implementation of the Diagnosis Related Group (DRG) hospital inpatient payment methodology, the Selective Provider Contracting Program (SPCP) contract and noncontract hospital per diem rate methodology was discontinued for private hospitals. Non-Designated Public Hospitals (NDPHs) will transition to the DRG reimbursement methodology on January 1, 2014. Although the contract and noncontract hospital designations are eliminated under the DRG, noncontract hospital inpatient cost settlements for dates prior to the DRG implementation will continue as required by W&I Code 14170.

Reason for Change from Prior Estimate:
The changes are due to updated expenditure data.

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NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 183

Methodology:

1. In FY 2012-13, total noncontract hospital inpatient cost settlements payments were $11.49 million TF.

2. Based upon payments made through August 2013, noncontract hospital cost settlements are estimated to total $11,487,000 in FY 2013-14 and $8,501,000 in FY 2014-15.

(Dollars in Thousands)	TF	GF	FF
FY 2013-14	**$11,487**	**$5,743**	**$5,744**
FY 2014-15	**$8,501**	**$4,250**	**$4,251**

Funding:

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

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CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	2/2012
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1629

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,430,000	$11,430,000
- STATE FUNDS	$11,430,000	$11,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,430,000	$11,430,000
STATE FUNDS	$11,430,000	$11,430,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from California Department of Development Services (CDDS) to pay claims for CDDS consumers whose dental services are no longer covered by Medi-Cal.

Authority:
Interagency Agreement (IA) 10-87244

Interdependent Policy Changes:
Not Applicable

Background:
The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal no longer covers most dental services for adults 21 years of age and older, CDDS entered into an IA with the Department to have the Medi-Cal dental Fiscal Intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of claims processing and benefits will be reimbursed by CDDS. Processing of CDDS claims started on January 12, 2012.

This policy change estimates the reimbursement of benefit costs. The reimbursement of administration costs is budgeted in the Other Administration CDDS Dental Services policy change.

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

Methodology:
1. Reimbursements began in February 2012.

2. Assume the benefit costs will be $11,430,000 annually.

Funding:
Reimbursement GF (4260-610-0995)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	7/2010
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1526

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$20,565,000	$16,415,000
- STATE FUNDS	$8,740,000	$6,481,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,565,000	$16,415,000
STATE FUNDS	$8,740,000	$6,481,000
FEDERAL FUNDS	$11,825,000	$9,934,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
The CDDS makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs, so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2013-14 and FY 2014-15. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 185

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDS.

Reason for Change from Prior Estimate:
Updated expenditure data due to delay in prior years billing schedule.

Methodology:
The following estimates have been provided by CDDS:

FY 2013-14* (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$3,844	$7,647	$22,981	$2,416	**$8,740**	**$11,825**

FY 2014-15* (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$1,500	$8,322	$18,116	$1,702	**$6,481**	**$9,934**

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

*Actuals may differ due to rounding.

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	4/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1826

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$7,837,000	$0
- STATE FUNDS	$2,351,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,837,000	$0
STATE FUNDS	$2,351,000	$0
FEDERAL FUNDS	$5,486,000	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to Indian Health Services/Memorandum of Agreement 638 (IHS/MOA 638) clinics for services provided to Medicare/Medi-Cal crossover beneficiaries.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
Tribal health programs can elect to participate in Medi-Cal as IHS/MOA 638 providers and receive a federally established annual rate for Medi-Cal visits.

IHS/MOA 638 clinics did not receive the full federal per visit rate for services provided to Medi-Cal Crossover beneficiaries between calendar years (CYs) 2009 through 2012. The Department did not disperse the full amount of the Medicare and/or Medi-Cal payment for the billed procedure code 02. IHS/MOA 638 clinics were not required to provide the annual reconciliation reports during that time period. Due to the expansion of the Medi-Cal Managed Care program to all counties, IHS/MOA 638 clinics are now required to submit the reconciliation reports to the Department. The Department has made the proper payment adjustments for claims after CY 2012.

Reason for Change from Prior Estimate:
This is a new policy change.

Methodology:
1. Assume a total of $7,837,000 was underpaid to 50 IHS/MOA 638 clinics for services rendered to crossover beneficiaries from CYs 2009 through 2012.

2. $3,135,000, or 40% of the $7,837,000, is estimated to be eligible for 100% Federal Medical Assistance Percentage (FMAP). This estimate was based on a paid claims report where 40% of

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER: 186

the beneficiaries were American Indians.

3. The remaining $4,702,000 will be funded at a regular 50% FMAP.

4. Assume a one-time reconciliation payment to be made in FY 2013-14.

FY 2013-14	TF	GF	FF
FY 2008-09	$986,000	$296,000	$690,000
FY 2009-10	$1,997,000	$599,000	$1,398,000
FY 2010-11	$1,967,000	$590,000	$1,377,000
FY 2011-12	$1,921,000	$576,000	$1,345,000
FY 2012-13	$966,000	$290,000	$676,000
Total for FY 2013-14	**$7,837,000**	**$2,351,000**	**$5,486,000**

Funding:
100% Title XIX (4260-101-0890)
50% GF / 50% Title XIX (4260-101-0001/0890)

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AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	9/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	110

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,247,000	$627,000
- STATE FUNDS	$8,247,000	$627,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,247,000	$627,000
STATE FUNDS	$8,247,000	$627,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:
Public Law 95-452

Interdependent Policy Changes:
Not Applicable

Background:
The Department reached audit settlements with the Office of Inspector General (OIG):

- Federal audit A-09-11-02040 regarding family planning services provided by the Family Planning Access, Care and Treatment (FPACT) program. The OIG found several claims that were not eligible for the claimed 90% federal Medicaid reimbursement for family planning services. The majority of claims were ineligible for reimbursement since the primary purpose of the beneficiary's visit was not family planning.
- Federal audit A-09-12-02077 regarding drug and supplies provided by the FPACT program. The OIG found several claims were not eligible for the claimed 90% federal Medicaid reimbursement for family planning services. The majority of the claims were ineligible for reimbursement due to the primary purpose of the visit was not family planning.
- Federal audit A-09-11-02016 regarding unallowable Medi-Cal payments for items and services furnished, ordered, or prescribed by excluded providers. The OIG found Medi-Cal payments made to excluded providers that were not eligible for FFP.
- Federal audit A-09-12-02047 regarding credit balances. OIG found credit balances with Medi-Cal providers. These claims contained overpayments to providers.
- Federal audits A-09-09-92146 (2007), A-09-09-94256 (2008), A-09-10-13500 (2009), A-09-11-15988 (2010), and A-09-12-18730 (2011) evaluated the effectiveness of the Department's internal controls related to preventing or detecting material noncompliance with laws, regulations, contracts and grants applicable to each of the federal programs.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187

- Federal audit A-09-07-00039 regarding claimed drug products not listed on the quarterly drug tapes and conclusive evidence that the drugs were eligible was not provided.

Reason for Change from Prior Estimate:
The change is due to payments scheduled to be made in FY 2012-13 delay to FY 2013-14 and new audit settlements.

Methodology:

1. The Federal audit A-09-07-02040 identified claims where the beneficiary's primary purpose was not family planning. The Department will return $5,671,000 FFP to CMS in FY 2013-14.

2. The Federal audit A-09-12-02077 identified drug and supplies where the beneficiary's primary purpose was not family planning. The Department will return $627,000 FFP to CMS in FY 2014-15.

3. The Federal audit A-09-11-02016 identified unallowable payments make for items and services furnished, ordered, or prescribed by excluded providers. The Department will return $1,030,720 FFP to CMS in FY 2013-14. Of this total amount, $1,009,300 was reimbursed to the Department in FY 2012-13 from the Department of Social Services.

4. Federal audit A-09-12-02047 identified 63 Medi-Cal claims that total's $6,961 in overpayments. The federal share is $4,040. The Department will return $4,040 FFP to CMS in FY 2013-14.

5. The following Federal audits relate to the annual Statewide Compliance Audits:
   - A-09-09-92146 (2007) identified paid claims that either were not deemed medically necessary, claims billed by a provider not rendering the service to the Medi-Cal beneficiary, or claims that did not have sufficient supporting documentation to support whether the required medical procedures were rendered to the beneficiary. The Department will return $1,739 FFP to CMS in FY 2013-14.
   - A-09-09-94256 (2008) identified paid claims that either were not deemed medically necessary, or claims that did not have sufficient supporting documentation to support whether the required medical procedures were rendered to the beneficiary. The Federal audit also identified a missing signature page from an agreement with a provider. The Department will return $9,046 to CMS in FY 2013-14.
   - A-09-10-13500 (2009) identified paid claims that either were not deemed medically necessary, or claims that did not have sufficient supporting documentation to support whether the required medical procedures were rendered to the beneficiary. The Federal audit also identified a provider agreement was missing, or a provider agreement was missing at the Department of Public Health. The Department will return $101,181 to CMS in FY 2013-14.
   - A-09-11-15988 (2010) identified paid claims that either were not deemed medically necessary, or claims that did not have sufficient supporting documentation to support whether the required medical procedures were rendered to the beneficiary, or a missing claim form. The Federal audit also identified that one provider sampled was missing documentation of an active license, application, provider agreement and disclosure statement, and three facility providers sampled did not have a provider agreement. The Department will return $9,247 to CMS in FY 2013-14.
   - A-09-12-18730 (2011) identified paid claims that either were not deemed medically necessary, or claims that did not have sufficient supporting documentation to support whether the required medical procedures were rendered to the beneficiary. The Department will return $13,941 to CMS in FY 2013-14.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187

6. Federal audit A-09-07-00039 identified that $820,817 of claimed FFP for National Drug Code associated with manufacturers was not active in the Medicaid Drug Rebate Program during the quarter in which claims were paid. The audit also identified $584,951 of non-drug products that were misclassified in the federal CMS-64 report.

FY 2013-14		**TF**	**GF**
A-09-11-02016	Excluded Providers	$1,031,000	$1,031,000
A-09-11-02040	FPACT-Planning Services	$5,671,000	$5,671,000
A-09-12-02047	Credit Balance Review	$4,000	$4,000
A-09-07-00039	Unsupported Costs	$1,406,000	$1,406,000
	Annual Single Audits:		
A-09-09-92146	2007	$2,000	$2,000
A-09-09-94256	2008	$9,000	$9,000
A-09-10-13500	2009	$101,000	$101,000
A-09-11-15988	2010	$9,000	$9,000
A-09-12-18730	2011	$14,000	$14,000
	Total	**$8,247,000**	**$8,247,000**

FY 2014-15		**TF**	**GF**
A-09-12-02077	FPACT-Drugs Review	**$627,000**	**$627,000**

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

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INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	191
IMPLEMENTATION DATE:	4/1998
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	111

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,254,000	$2,180,000
- STATE FUNDS	-$9,435,500	-$9,435,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,254,000	$2,180,000
STATE FUNDS	-$9,435,500	-$9,435,500
FEDERAL FUNDS	$10,689,500	$11,615,500

DESCRIPTION

Purpose:
This policy change estimates the annual rate change posted in the Federal Register and the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to Native Americans eligible for Medi-Cal.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to Native Americans through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian Health Clinics is adjusted annually through changes posted in the *Federal Register*. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

Reason for Change from Prior Estimate:
The change is due to the annual rate adjustment.

Methodology:
1. Currently, there are 52 Indian health clinics participating in Medi-Cal.

2. In fiscal year (FY) 2012-13, the Department spent $18,871,000.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 191

3. Recent changes posted in the Federal Register, Volume 78, Number 74, April 17, 2013 updated the per visit rate payable to Indian Health Clinics. Effective calendar year 2013, the per visit rate payable to Indian Health Clinics increased $14, from $316 to $330.

4. The FY 2013-14 budget includes an additional $418,000 due to the increased rate for the period of January 2013 through June 2013. The annual rate increase for the additional $14 is $836,000.

5. The FY 2014-15 budget includes an additional $448,000 due to the anticipated rate increase to $345 from $330 for the period of January 2014 through June 2014. The annual rate increase for the additional $15 is $896,000.

	FY 2013-14	FY 2014-15
CY 2013 rate increase	$836,000	$836,000
CY 2014 rate increase	$0	$896,000
Retro Jan –June 2013 rate increase	$418,000	$0
Retro Jan –June 2014 rate increase	$0	$448,000
Total rate increase	$1,254,000	$2,180,000
FY 2012-13 Base expenditures	$18,871,000	$18,871,000
Total expenditures	$20,125,000	$21,051,000

Funding:
(Dollars In Thousands)

FY 2013-14:		TF	GF	FFP
50% GF / 50% Title XIX FFP	4260-101-0001/0890	($18,871)	($9,436)	($9,436)
100% Title XIX FFP	4260-101-0890	$20,125		$20,125
Net Impact		**$1,254**	**($9,436)**	**$10,690**

FY 2014-15:		TF	GF	FFP
50% GF / 50% Title XIX FFP	4260-101-0001/0890	($18,871)	($9,436)	($9,436)
100% Title XIX FFP	4260-101-0890	$21,051		$21,051
Net Impact		**$2,180***	**($9,436)**	**$11,615**

*Totals may differ due to rounding.

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CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	192
IMPLEMENTATION DATE:	1/2006
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1087

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2012-13 and FY 2013-14. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change also estimates the CTPS/Proposition 99 funding added by the Budget Act of 2010, which provides additional funding for Medi-Cal hospital outpatient services.

Reason for Change from Prior Estimate:
There is an increase in FY 2013-14 due to an increase in the Unallocated Account. In FY 2014-15, there will be an increase in both the Hospital Services Account and the Unallocated Amount.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 192

Methodology:

FY 2013-14	
Hospital Services Account	$58,946,000
Physicians' Services Account	$105,000
Unallocated Account	$23,540,000
Total CTPS/Prop. 99	$82,591,000
GF	($82,591,000)
Net Impact	**$0**

FY 2014-15	
Hospital Services Account	$72,435,000
Physicians' Services Account	$105,000
Unallocated Account	$26,991,000
Total CTPS/Prop. 99	$99,531,000
GF	($99,531,000)
Net Impact	**$0**

Funding:
Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

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ANTI-FRAUD ACTIVITIES

REGULAR POLICY CHANGE NUMBER:	193
IMPLEMENTATION DATE:	1/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1474

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$15,000,000	-$15,000,000
- STATE FUNDS	-$7,500,000	-$7,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the savings resulting from expanding anti-fraud activities for pharmacy and physician services.

Authority:
Welfare & Institutions Code, section 14123.25

Interdependent Policy Change:
Not Applicable

Background:
In January 2012, the Department expanded its anti-fraud activities for pharmacy and physician services.

Pharmacy Services Activities
The Department uses data mining techniques to identify providers and beneficiaries involved in suspicious activities related to abuse of prescriptions, institute a beneficiary lock-in program, apply administrative sanctions to providers found to be involved in unnecessary claiming, and address fraud related to medically unnecessary incontinence supplies.

Physicians Services Activities
The Department conducts rapid response and compliance-focused sweeps of suspicious associations of providers and organized groups; targets clinics involved in networks of fraud; provides statewide group training classes for providers; and provides training to providers identified with billing irregularities to ensure the type and level of services provided adhere to current medical practices and Medi-Cal statutes and regulations.

Reason for Change from Prior Estimate:
The change is due to the updated cost savings produced by the Individual Provider Claims Analysis Report project.

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ANTI-FRAUD ACTIVITIES

REGULAR POLICY CHANGE NUMBER: 193

Methodology:

1. Savings are estimated to be $15,000,000 annually.

2. Savings are fully phased in.

Funding:

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

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	7/2005
ANALYST:	Yumie Park
FISCAL REFERENCE NUMBER:	1633

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change appropriates the funding for blood lead tests performed by the Medi-Cal program. It estimates the technical adjustment in funding from 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

Authority:
Health & Safety Code, Sections 105305, 105310, and 124075
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides blood lead tests to children who are at risk for lead poisoning, and who are:

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The state share of cost for the lead testing component is partly funded by the CLPP Fund. The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate. This policy change adjusts the CLPP funding.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products, and collected by the Board of Equalization.

Reason for Change from Prior Estimate:
The IA has been updated to reflect the estimated cost of the blood lead testing to the Medi-Cal program.

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CLPP FUND

REGULAR POLICY CHANGE NUMBER: 194

Methodology:

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.

2. The current IA with the Department of Public Health expired at the end of FY 2012-13. It is assumed that the IA will be extended for another three years, and the CLPP funding allocated for FY 2013-14 and FY 2014-15 will be $714,000.

	CLPP Fund
Total FY 2013-14	**$714,000**
Total FY 2014-15	**$714,000**

Funding:

CLPP Fund (4260-111-0080)
GF (4260-101-0001)

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	4/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1621

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to implementation of a quality assurance fee (QAF) for hospitals from July 1, 2011 to December 31, 2013.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)

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:
SB 335 establishes a hospital QAF program for the period beginning July 1, 2011 to December 31, 2013. The Centers for Medicare and Medicaid Services (CMS) approved the extension of the hospital QAF program on June 22, 2012.

AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Eliminating grant payments to DPHs in FY 2013-14, and
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14.

The grant and managed care supplemental payments are budgeted in the Hospital QAF – Hospital

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 195

Payments policy change.

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

Methodology:
1. On an accrual basis, annual funds for children's health care coverage are:

(Dollars In Thousands)	Children's Health Care Coverage
FY 2012-13	$537,000
FY 2013-14	$310,000
Total	$847,000

2. On a cash basis, the estimated receipts of funds for children's health care coverage are:

(Dollars In Thousands)	TF	GF	Hosp. QA Rev Fund
FY 2012-13	$0	($134,250)	$134,250
FY 2013-14	$0	($310,000)	$310,000
FY 2013-14 Total	**$0**	**($444,250)**	**$444,250**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

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AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER:	196
IMPLEMENTATION DATE:	7/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1656

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the erosion of savings related to injunctions preventing the implementation of Assembly Bill (AB) 97 payment reductions. The injunctions were lifted on June 25, 2013. The Department will implement AB 97 payment reduction retroactive to June 1, 2011 to the affected providers.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
AB 97 (Chapter 3, Statutes of 2011) requires the Department to implement a 10% provider payment reduction and rate freeze, which will affect all services except hospital inpatient and outpatient services, critical access hospital, federal rural referral centers and Federally Qualified Health Center/ Rural Health Clinic (FQHCs/RHCs), services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs, and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt.

AB 97 requires the Department to implement a payment reduction of up to 10% to specified fee-for services (FFS) providers, effective June 1, 2011. The actuarial equivalent of that amount to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

On October 27, 2011, the Department received federal approval to reduce applicable providers' payments up to 10%.

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 196

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *California Hospital Association, et al. v. Douglas et al.* against the implementation of AB 97 payment reductions for distinct part nursing facilities. In compliance with these injunctions, the Department was enjoined from implementing the rate freeze and 10% payment reductions. On March 8, 2012, the district court issued an order modifying the injunction to allow the Department to apply the rate freeze and 10% payment reduction to services rendered June 1, 2011 through December 27, 2011, that were not reimbursed prior to December 28, 2011 at the unreduced level.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *Managed Pharmacy Care, et al. v. Sebelius, et al.* against the implementation of AB 97 payment reductions for pharmacy services. In compliance with these injunctions, the Department was enjoined from implementing the 10% payment reduction for prescription drugs. On March 12, 2012, the district court issued an order modifying the injunction to allow DHCS to apply the 10% payment reduction to prescription drugs provided from June 1, 2011 through December 27, 2011 that were not reimbursed prior to December 28, 2012 at the unreduced level.

On January 10, 2012, the same court issued a preliminary injunction in the case of *California Medical Transportation Association v. Douglas, et al.* prohibiting the Department from implementing 10% payment reductions for non-emergency medical transportation providers. The court subsequently modified the injunction to allow DHCS to implement the 10 % payment reduction for NEMT services rendered June 1, 2011 through January 9, 2012 that had not been reimbursed prior to January 10, 2012 at the unreduced payment level.

On January 31, 2012, a preliminary injunction was issued in the case of *California Medical Association, et al. v. Douglas, et al.* against the implementation of AB 97 payment reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment except for services rendered June 1, 2011 through January 30, 2012 that had not been reimbursed prior to January 31, 2012 at the unreduced payment level. In compliance with this injunction, the Department was enjoined from implementing a 10% payment reduction.

On February 22, 2012, the United States Supreme Court issued its decision in the *Douglas v. Independent Living Center* Medi-Cal payment reductions cases. The 5-4 majority opinion vacated all of the Ninth Circuit decisions that were before it and remanded the cases to the Ninth Circuit Court of Appeals to reassess the plaintiffs' preemption/Supremacy Clause claims in light of the Centers for Medicare & Medicaid Services (CMS) approval of the State Plan Amendments (SPA) at issue in a number of those cases. The Supreme Court also strongly indicated that, on remand, the Ninth Circuit should show deference to CMS decisions to approve the SPAs, noting that CMS approval "carries weight".

On December 13, 2012, the United States Court of Appeals for the Ninth Circuit issued a decision in which it reversed the injunctions against AB 97 payment reductions issued in all four of the above cases. On January 28, 2013 the plaintiff requested a rehearing. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. The Department will implement the AB 97 FFS payment reduction and rate freeze retroactive to June 1, 2011. Managed care reductions will be implemented prospectively only, effective October 1, 2013.

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AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 196

Reason for Change from Prior Estimate:
The erosion of savings related to AB 97 injunction is incorporated into the 10% Payment Reduction for LTC Facilities and 10% Provider Payment Reduction policy changes.

Methodology:
Not Applicable

Funding:
Not Applicable

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TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER:	197
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1654

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Social Services (CDSS) to the Department for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles, partial dual eligibles and Medi-Cal only eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to manage care health plans beginning April 1, 2014.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the California Department of Social Services (CDSS) pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population. This policy change reflects the transfer of General Fund and county funds to the Department to be used to increase managed care capitation rates. An additional policy change, Transfer of IHSS Costs to CDSS, addresses the transfer of IHSS costs from managed care rates to the Department which will in turn transfer the funds to CDSS to pay the IHSS providers. For additional information about the transfer of IHSS costs to DHCS, see policy change Transition of Dual Eligibles-Long Term Care.

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TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 197

Reason for Change from Prior Estimate:
The implementation date changed from January 2014 to April 2014. Additionally, the phase-in schedule has been revised.

Methodology:
1. Estimated below is the overall impact of the Dual and LTC Integration proposal in FY 2013-14 and FY 2014-15.

(In Thousands)

FY 2013-14	**TF**	**GF**	**FFP**	**Reimbursement**
Managed Care Payments (PC 119):				
Non HCBS	$72,206	$36,103	$36,103	$0
HCBS	$53,221	$25,245	$27,976	$0
Existing Managed Care Duals	($149)	($75)	($74)	$0
Total	$125,278	$61,273	$64,005	$0
FFS Savings (PC 143):				
Non HCBS	($50,440)	($25,220)	($25,220)	$0
HCBS	($164)	($82)	($82)	$0
Defer Mgd. Care Payment	($90,107)	($45,054)	($45,053)	$0
Total	($140,711)	($70,356)	($70,355)	$0
IHSS FFS Savings (In the Base)	($21,973)	$0	($21,973)	$0
Delay 1 Checkwrite (In the Base)	$6,326	$3,163	$3,163	$0
Transfer of IHSS Costs to DHCS (PC 197)	**$0**	**($21,973)**	**$0**	**$21,973**
Transfer of IHSS Costs to CDSS (PC 123)	$45,505	$0	$0	$45,505
Other Administration Costs (OA 19)	$8,786	$2,543	$6,243	$0
Total of CCI PCs including pass through	$23,211	($25,350)	($18,917)	$67,478

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TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 197

(In Thousands)

FY 2014-15	TF	GF	FFP	Reimbursement
Managed Care Payments (PC 119):				
Non HCBS	$3,811,408	$1,905,704	$1,905,704	$0
HCBS	$1,898,211	$900,636	$997,575	$0
Existing Managed Care Duals	($2,715)	($1,358)	($1,357)	$0
Total	$5,706,904	$2,804,982	$2,901,922	$0
FFS Savings (PC 143):				
Non HCBS	($3,152,713)	($1,576,357)	($1,576,356)	$0
HCBS	($11,556)	($5,778)	($5,778)	$0
Defer Mgd. Care Payment	($624,574)	($312,287)	($312,287)	$0
Total	($3,788,843)	($1,894,422)	($1,894,421)	$0
IHSS FFS Savings (In the Base)	($782,780)	$0	($782,780)	$0
Delay 1 Checkwrite (In the Base)	$85,162	$42,581	$42,581	$0
Transfer of IHSS Costs to DHCS (PC 197)	**$0**	**($782,780)**	**$0**	**$782,780**
Transfer of IHSS Costs to CDSS (PC 113)	$1,615,660	$0	$0	$1,615,660
Other Administration Costs (OA 19)	$8,070	$2,543	$5,527	$0
Total of CCI PCs including pass through	$2,844,173	$172,905	$272,829	$2,398,440

Funding:
100% Reimbursement (4260-610-0995)
General Fund (4260-101-0001)

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EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	198
IMPLEMENTATION DATE:	6/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1760

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to extension of a quality assurance fee (QAF) for hospitals from January 1, 2014 to December 31, 2016.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

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:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016.

Reason for Change from Prior Estimate:
The change is due to delay in expected federal approval.

Methodology:
1. The current Hospital QAF program will end on December 31, 2013. Assume a 36-month extension for the Hospital QAF program beginning January 1, 2014 through December 31, 2016.

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 198

2. On an accrual basis, annual funds for children's health care coverage are:
   - FY 2013-14: $310,000,000
   - FY 2014-15: $744,500,000

   SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program. The FY 2014-15 amounts are the initial children's health care coverage funds calculation and may be adjusted based on the final reconciliation.

3. On a cash basis, the payments to health care coverage for children are:

(Dollars In Thousands)

	TF	GF	Hosp. QA Rev Fund
FY 2013-14	**$0**	**($155,000)**	**$155,000**
FY 2014-15			
FY 2013-14	$0	($155,000)	$155,000
FY 2014-15	$0	($558,375)	$558,375
Total	**$0**	**($713,375)**	**$713,375**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

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RECOVERY OF PCS/IHSS

REGULAR POLICY CHANGE NUMBER:	199
IMPLEMENTATION DATE:	1/2015
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1816

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$389,000
- STATE FUNDS	$0	-$194,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$389,000
STATE FUNDS	$0	-$194,500
FEDERAL FUNDS	$0	-$194,500

DESCRIPTION

Purpose:
This policy change estimates the recovery of costs for personal care services (PCS) provided under the In-Home Supportive Services (IHSS) program.

Authority:
Title 42, USC Section 1396p (b)(1)(B)(ii)
Welfare & Institutions Code, Section 14009.5 (a)
Proposed Regulations

Interdependent Policy Changes:
Not Applicable

Background:
In September 2000, the Department opted to discontinue recovery of costs related to PCS provided under IHSS (PCS/IHSS). The Department proposed regulations to recover PCS/IHSS for Medi-Cal beneficiaries after age 55.

The Department will only realize a 10% increase in estate recovery (ER) claims from PCS/IHSS, due to the following assumptions:

- IHSS patient's Medi-Cal usage is lower than the overall Medi-Cal population over age 55,
- Less available assets for recovery of ER claims,
- Higher number of hardship waiver exemptions due to care provided by the heir(s), and
- More cases will be written off because collection costs exceed lien.

Reason for Change from Prior Estimate:
This is a new policy change.

RECOVERY OF PCS/IHSS

REGULAR POLICY CHANGE NUMBER: 199

Methodology:

1. In FY 2011-12, the total Medi-Cal fee-for-service (FFS) expenditures for Medi-Cal beneficiaries age 55 or older totaled $10,745,092,000.

2. Of the $10,745,092,000 Medi-Cal expenditures, 29.53% was spent on the PCS/IHSS program.

   $10,745,092,000 x 29.53% = $3,173,360,000

3. Of the $10,745,092,000 Medi-Cal expenditures, the Department collected 0.49% for ER claims.

   $10,745,092,000 x 0.49% = $52,651,000

4. Assume the additional PCS/IHSS claims correlates to the percentage the Department collects in Medi-Cal ER claims.

   $3,173,360,000 x 0.49% = $15,549,000

5. Assume the Department will only recover 10% of the PCS/IHSS claims annually.

   $15,549,000 x 10% = $1,555,000

6. Assume the ER claims will include PCS costs for Medi-Cal beneficiaries over age 55 for all death notices received after July 2014.

7. Assume recovery takes six months from the date of ER claim and savings will begin January 1, 2015 and phase-in over the next six months.

8. Assume three months of savings in FY 2014-15.

	FY 2014-15	**Annually**
GF	($194,000)	($777,000)
FF	($195,000)	($778,000)
Total	**($389,000)**	($1,555,000)

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

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MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER:	200
IMPLEMENTATION DATE:	10/2012
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1587

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$4,000,000	-$2,400,000
- STATE FUNDS	-$3,800,000	-$2,280,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	82.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$720,000	$0
STATE FUNDS	-$684,000	$0
FEDERAL FUNDS	-$36,000	$0

DESCRIPTION

Purpose:
This policy change estimates recovery of overpayments from the Centers for Medicare and Medicaid Services (CMS) or Medicare providers.

Authority:
Welfare & Institutions Code 14124.90
Social Security Act 1634

Interdependent Policy Changes:
OA 46 Medicare Buy-In Quality Review Project

Background:
On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums. On May 17, 2012, the Department of General Services approved extending the agreement to June 30, 2015.

The contract costs are budgeted in the Medicare Buy-In Quality Review Project policy change.

Reason for Change from Prior Estimate:
There is no change in FY 2013-14. For FY 2014-15, based on the case projections from UMASS, it is assumed that there will be fewer new cases identified. Therefore, the recovery amounts will decrease.

Methodology:
1. The contractor began auditing invoices in July 2012.

2. Recovery of overpayments began October 2012.

MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 200

3. Assume that 90% of recoveries will be from CMS Medicare Premiums and 10% will be from provider overpayments.

4. Based on FY 2012-13 year-end recoveries of $3,243,318.70, it is assumed that recoveries will be $4,000,000 for FY 2013-14 and $2,400,000 for FY 2014-15.

(Dollars in Thousands)

	FY 2013-14			FY 2014-15		
	TF	**GF**	**FF**	**TF**	**GF**	**FF**
Provider Overpayments	($400)	($200)	($200)	($240)	($120)	($120)
Medicare Premiums *	($3,600)	($3,600)	$0	($2,160)	($2,160)	$0
TOTALS	**($4,000)**	**($3,800)**	**($200)**	**($2,400)**	**($2,280)**	**($120)**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% General Fund (4260-101-0001) *

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IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER:	201
IMPLEMENTATION DATE:	8/2012
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1746

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$196,331,000	-$190,614,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$196,331,000	-$190,614,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$196,331,000	-$190,614,000

DESCRIPTION

Purpose:
This policy change estimates the savings associated with reducing the hours of service for In-Home Supportive Services (IHSS) recipients by 8% in FY 2013-14 and 7% in FY 2014-15.

Authority:
Welfare & Institutions Code 12301.06
AB 1612 (Chapter 725, Statutes of 2010)
SB 1041 (Chapter 47, Statutes of 2012)
Oster v. Lightbourne and *Dominguez v. Schwarzenegger* Settlements

Interdependent Policy Changes:
Not Applicable

Background:
Personal care services are rendered under the administrative direction of the California Department of Social Services (CDSS) for the IHSS program.

AB 1612 implemented a 3.6% across-the-board reduction in services hours for IHSS effective February 1, 2011 with a sunset date of June 30, 2012. Subsequently, through SB 1041, the 3.6% across-the-board reduction was extended for 11 months from August 2012 through June 2013. Recipients may determine which of their services will be impacted by the reduction.

In accordance with the IHSS Settlement Agreement, filed March 28, 2013, IHSS service hours were reduced by 8% (net impact 6.79%) effective July 1, 2013. This reduction will be lowered to 7% (net impact 6.47%) effective July 1, 2014. The IHSS settlement resolves two class-action lawsuits: *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*.

Reason for Change from Prior Estimate:
The FY 2013-14 savings were increased due to higher average hours per case prior to the reduction.

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IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER: 201

Methodology:
The estimated savings are provided by CDSS.

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

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER:	205
IMPLEMENTATION DATE:	9/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1831

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$121,306,000
- STATE FUNDS	$0	$54,587,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$121,306,000
STATE FUNDS	$0	$54,587,500
FEDERAL FUNDS	$0	$66,718,500

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases to fund the federally required Health Insurer Fee.

Authority:
The Affordable Care Act (ACA)

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 ACA places an $8 billion fee on the health insurance industry nationwide beginning January of 2014. The fee grows to $14.3 billion in 2018 and is trended based on the rate of premium growth after 2018. The fee will be allocated to qualifying health insurers based on their market share of premium revenue in the previous year. Market share is based on commercial, Medicare, Medicaid, and State Children Health Insurance Plan (SCHIP) premium revenues. Nonprofit insurers that receive more than 80% of their premium from non-commercial business (Medicare, Medicaid and SCHIP), are exempt from the fee. The fee is not exempt from corporate income tax, therefore the cost to the plans will be compounded by the tax that must be assessed to the revenue from the additional premium to the managed care plans to account for the Health Insurer Fee.

Reason for Change from Prior Estimate:
This is a new policy change

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HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 205

Methodology:

1. It is estimated that the increase in premiums to Medi-Cal managed care over a 5 year period will be approximately $536 million TF, including the cost of the fee and the cost of the associated corporate income tax on that revenue.

2. This fee will apply to Medi-Cal premiums for existing Medi-Cal beneficiaries (currently funded at 50% FMAP, and the expansion population, which will be funded at 100% FMAP. Therefore, this estimate assumes an overall FMAP of 55%.

3. Fees will be assessed to the plans by the federal government effective January 1, 2014. However, capitation rate increases will not occur until approximately September 2014. It is estimated that all payments for FY 2013-14 and FY 14-15 will be made in FY 2014-15.

4. Assume the amount attributable to FY 2013-14 will be $33,853,000, and the amount attributable to FY 2014-15 will be $87,453,000.

Funding:

Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)

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ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	206
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1834

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$71,535,000	$687,214,000
- STATE FUNDS	$1,204,400	$11,586,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$71,535,000	$687,214,000
STATE FUNDS	$1,204,400	$11,586,150
FEDERAL FUNDS	$70,330,600	$675,627,850

DESCRIPTION

Purpose:
This policy change estimates the cost of additional Medi-Cal eligibles through use of the Express Lane option for enrollment.

Authority:
SBx1 1 (Chapter 4, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
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% of the federal poverty level (FPL). The ACA expansion includes:

- ACA Mandatory Expansion: cover the currently Medi-Cal eligible but not enrolled beneficiaries.
- ACA Optional Expansion: expand coverage to newly eligibles.

The Centers for Medicare and Medicaid Services (CMS) has provided options for the states to facilitate enrollment into Medicaid programs. These Express Lane Enrollment options would alleviate the influx of applications on the new enrollment system for ACA. This is accomplished by giving Medicaid eligibility to targeted groups of individuals without the need to conduct a separate Modified Adjusted Group Income (MAGI) based determination for the first twelve months. The assumption is that these targeted groups would, with a high degree of certainty, be eligible for Medi-Cal if a MAGI-based eligibility were conducted.

One of the CMS options is a waiver that would simplify the enrollment process for those receiving Supplemental Nutrition Assistance Program (SNAP) benefits. In California this program is known as CalFresh. Another option is a waiver that would address enrollment for parents based upon the children's income eligibility. SBx1 1 requires the Department to seek federal waivers to implement these two options.

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ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 206

Reason for Change from Prior Estimate:
New policy change

Methodology:

1. Based upon special reports comparing Medi-Cal eligibles to other program eligibles, the following is the estimated number of enrollees who could potentially be eligible for Medi-Cal after implementation of the ACA on January 1, 2014:

a. CalFresh childless adults	730,000
b. CalFresh children	156,000
c. Parents/caretaker relatives of Medi-Cal eligible children	150,000
d. Total	1,036,000

2. It is assumed that 30% of the potential eligibles will respond and be found eligible.
   1,036,000 potential eligibles x 30% found eligible = 310,800 eligibles

3. Of those found eligible, it is assumed that 50% will be new eligibles, not accounted for in the ACA Mandatory Expansion and ACA Optional Expansion policy changes.
   310,800 eligibles x 50% new eligibles = 155,400 new eligibles

4. Assume that the new eligibles will phase-in between April and September 2014, with two-thirds in the first quarter and one-third in the second quarter.

5. Based upon the above assumptions, total member months of new eligibles will be:

Member Months	FY 2013-14	FY 2014-15
Adults	176,000	1,540,000
Children	31,200	273,000
Total	207,200	1,813,000

6. The PMPM costs include managed care, dental and fee-for-service/other services that are not included in the managed care capitation. The average PMPM, including appropriate payment lags, is estimated to be:

PMPM	FY 2013-14	FY 2014-15
Adults	$391.41	$429.71
Children	$84.84	$93.28

7. Adults are assumed to qualify for ACA 100% federal funding.

8. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% funding, while the rest qualify for Title XIX 50% funding.

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ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 206

Funding:

	Title XXI*	Title XIX**	ACA Title XIX***	Total
FY 2013-14	**$794,000**	**$1,853,000**	**$68,888,000**	**$71,535,000**
FY 2014-15	**$7,639,000**	**$17,825,000**	**$661,750,000**	**$687,214,000**

*Title XXI 65/35 (4260-113-0001/0890)
**Title XIX 50/50 (4260-101-0001/0890)
***100% Title XIX FFP (4260-101-0890)

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DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER:	208
IMPLEMENTATION DATE:	7/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1832

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$17,467,000
- STATE FUNDS	$0	$8,098,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$17,467,000
STATE FUNDS	$0	$8,098,000
FEDERAL FUNDS	$0	$9,369,000

DESCRIPTION

Purpose:
The policy change estimates the cost of implementing strategies to increase utilization rates for children. This policy estimates the increase in outreach activities and dental utilization for children ages 0-3.

Authority:
Not Applicable

Interdependent Policy Changes:
PC 208 Dental SMA Rate Increase Ages 0-5

Background:
Based on recommendations from the federal Centers for Medicare and Medicaid Services (CMS) and pursuant to requirements of the Healthy Families Program transition, the Department has identified effective strategies which will have positive health outcomes while increasing utilization of services for children. Specifically, the Department will identify beneficiaries age 0-3 on their birth months that have not had a dental visit during the past 12 months and mail parents/legal guardians of these individuals a letter encouraging them to take their children to see a dental provider as well as educational information about the importance of early dental visits.

Reason for Change from Prior Estimate:
This is a new policy change.

Methodology:
1. Assume the mailing campaign to beneficiaries age 0-3 will begin in July 2014.

2. Assume the mailing campaign will result in an increase of 10% in annual utilization for children age 0-3.

3. The 10% increase in the number of eligibles who are users will increase users by 77,985.

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER: 208

4. The average cost per user aged 0-5 is $272.51.

   77,985 x $272.51 = $21,252,000

5. An estimated 20% will be Title XXI Healthy Families.

   $21,252,000 x 20% = $4,250,000

6. For administrative costs, assume that there will be a 910,085 increase in Adjudicated Claim Service Line's (ACSL) with a $0.9427 cost per ACSL. Assume that there are 536,792 eligibles that letters would be sent to with $0.23 per letter and $0.04 per print.

   910,085 x $0.9427 = $ 858,000 ACSL
   536,792 x $0.23 = $ 123,000 Postage/mailing
   536,792 x $0.04 = $ 22,000 Printing
   $1,003,000

7. The annualized impact based upon FY 2014-15 costs is:

   $21,252,000 increased benefits + $1,003,000 administrative cost = $22,255,000 Total

8. Assume that reimbursement will be provided by the California First 5 Commission for the non-federal share of costs.

9. Based upon an assumed 6 month phase-in, the impact in FY 2014-15 is

FY 2014-15	TF	Reimbursement
Title XIX (50/50)	$ 13,459,000	$ 6,730,000
Title XXI (65/35)	$ 3,365,000	$ 1,178,000
Title XIX (various) (Admin.)	$ 643,000	$ 190,000
Total	**$ 17,467,000**	**$ 8,098,000**

Funding:
100% Title XIX (4260-101-0890)
100% Title XXI (4260-113-0890)
Reimbursement GF (4260-610-0995)

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ACA EXPANSION-PREGNANCY ONLY

REGULAR POLICY CHANGE NUMBER:	210
IMPLEMENTATION DATE:	1/2015
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1794

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$33,145,000
- STATE FUNDS	$0	-$16,572,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$33,145,000
STATE FUNDS	$0	-$16,572,500
FEDERAL FUNDS	$0	-$16,572,500

DESCRIPTION

Purpose:
This policy change estimates the savings from current pregnant women with incomes up to 200% of the federal poverty level (FPL) who receive pregnancy-only services electing to receive coverage through the California Health Benefit Exchange (Covered California) beginning January 1, 2015.

Authority:
Proposed legislation.

Interdependent Policy Changes:
Not Applicable

Background:
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 optional expansion population to result in a significant number of new Medi-Cal beneficiaries. Additionally, the ACA requires states to participate in health benefit exchanges, whether they establish their own, partner with other states in a multi-state exchange, or have a federal government administered exchange. The health benefit exchange will provide the public with the ability to purchase health coverage. Individuals with incomes below 400% FPL will be eligible for federal subsidies to help offset the monthly premium costs. California developed a state-operated Health Benefit Exchange called Covered California, which is currently open for the public. Covered California will only be available for citizens and legal immigrants to purchase health coverage.

Pregnant women with incomes up to 200% of the FPL are eligible for Medi-Cal pregnancy-only coverage and coverage under Covered California. (Effective January 1, 2014, the 200% of FPL is 208% to reflect the new Modified Adjusted Gross Income method of determining eligibility.) Pregnancy-only coverage is limited to pregnancy related services throughout the entire pregnancy.

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ACA EXPANSION-PREGNANCY ONLY

REGULAR POLICY CHANGE NUMBER: 210

This policy change estimates the savings from some pregnant women receiving pregnancy-only services through Medi-Cal electing to receive full coverage from Covered California. The Department will cover all out-of-pocket expenditures that may occur from shifting into Covered California.

Reason for Change from Prior Estimate:
Implementing legislation was not enacted. Therefore, the Department cannot implement the "wrap around" payments until January 1, 2015.

Methodology:

1) Beginning January 1, 2015, the Department estimates 8,100 beneficiaries currently receiving pregnancy only coverage will shift into Covered California. The Department will implement a wraparound of potential differences in benefits and out-of-pocket expenditures related to shifting to Covered California.

2) The total estimated savings in FY 2014-15 is:

(in thousands)	TF	GF	FF
FY 2014-15 savings	**($33,145)**	**($16,573)**	**($16,572)**

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

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MCO SUPPLEMENTAL DRUG REBATE

REGULAR POLICY CHANGE NUMBER:	211
IMPLEMENTATION DATE:	4/2015
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1836

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$65,000,000
- STATE FUNDS	$0	-$32,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$65,000,000
STATE FUNDS	$0	-$32,500,000
FEDERAL FUNDS	$0	-$32,500,000

DESCRIPTION

Purpose:
This policy change estimates revenues collected from Managed Care Organization (MCO) Supplemental Drug rebates.

Authority:
Welfare & Institutions Code, section 14105.33

Interdependent Policy Changes:
Not Applicable

Background:
Previously, state supplemental drug rebates for drugs provided through fee-for-service (FFS) and County Organized Health Systems (COHS) have been negotiated by the Department with drug manufacturers providing additional drug rebates over and above mandatory federal rebate levels. Effective July 1, 2014, the Department will include Medicaid MCO outpatient covered drug utilization data for the purposes of determining additional state supplemental rebates. MCO supplemental drug rebates shall be payable retroactive to July 1, 2014.

The Department anticipates the savings associated with MCO supplemental rebates to increase in future years, as the ability to negotiate and contract for higher supplemental rebates in future years is strengthened by the increased population base of the managed care program.

Reason for Change from Prior Estimate:
This is a new Policy Change.

Methodology:
1. Rebates are estimated by using COHS Plan rebate data for drug utilization and expenditures.

2. Assume MCO supplemental drug rebate alignment will provide rebate levels similar to current COHS drug utilization.

MCO SUPPLEMENTAL DRUG REBATE

REGULAR POLICY CHANGE NUMBER: 211

3. Assume 3% will be collected in Managed Care supplemental drug rebates based on projected managed care pharmacy expenditures (Two-Plan Model, Geographic Managed Care) of $788 million for FY 2012-13.

4. The Department estimates $130 million TF ($65 million GF) in managed care supplemental drug rebates for FY 2014-15 annually.

5. Because of the lag for rebate billing and collection, 41% will be collected in FY 2014-15.

6. Rebates are invoiced quarterly. Assume invoicing will begin no later than March 31, 2015.

(Dollars in Thousands)

	TF	FF	GF
FY 2014-15	**($53,000)**	**($26,500)**	**($26,500)**

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

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AIM LINKED MOTHERS 200-300% FPL

REGULAR POLICY CHANGE NUMBER:	212
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1837

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$128,655,000
- STATE FUNDS	$0	$57,459,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$128,655,000
STATE FUNDS	$0	$57,459,000
FEDERAL FUNDS	$0	$71,196,000

DESCRIPTION

Purpose:
This policy change estimates the benefits cost to transition the Access for Infants and Mothers (AIM) linked mothers with incomes between 200-300% into the Medi-Cal delivery system.

Authority:
SB 800 (Chapter 448, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2014, AIM linked mothers will transition into the Medi-Cal delivery system. Mothers who paid premiums with Managed Risk Medical Insurance Board (MRMIB) will continue paying premiums for coverage following the transition into the Medi-Cal delivery system.

The AIM linked mothers program is funded with Cigarette and Tobacco Surtax Revenues (Proposition 99), subscriber fees, and Title XXI funding.

Reason for Change from Prior Estimate:
This is a new policy change.

Methodology:
1. Effective July 1, 2014, approximately 852 eligible pregnant women with incomes between 200-300% FPL will transition into the Medi-Cal delivery system.

2. The Department assumes MRMIB will budget the costs for the AIM linked mothers in FY 2013-14.

3. MRMIB provided the estimated costs for FY 2014-15 on a cash basis.

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AIM LINKED MOTHERS 200-300% FPL

REGULAR POLICY CHANGE NUMBER: 212

(In Thousands)	TF	SF	FF
FY 2014-15	**$128,655**	**$57,459**	**$71,196**

Funding:
Perinatal Insurance Fund (4260-602-0309)
Title XXI FFP (4260-113-0890)