

## November 2013 Medi-Cal Estimate

### Current Year (FY 2013-14) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

Total Medi-Cal local assistance expenditures in the Department of Health Care Services (DHCS) budget in the Current Year as compared to the Appropriation are as follows:

<b>Medical Care Services</b>	<b>FY 2013-14 Appropriation</b>	<b>Nov 2013 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$65,196.9	\$65,641.0	\$444.1	0.7%
Federal Funds	\$39,373.7	\$40,559.8	\$1,186.1	3.0%
<b>General Fund</b>	<b>\$15,076.4</b>	<b>\$15,294.2</b>	<b>\$217.8</b>	<b>1.4%</b>
Other Non-Federal Funds	\$10,746.8	\$9,787.0	(\$959.8)	-8.9%

<b>County Administration</b>	<b>FY 2013-14 Appropriation</b>	<b>Nov 2013 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$3,980.3	\$3,622.5	(\$357.8)	-9.0%
Federal Funds	\$3,071.2	\$2,798.7	(\$272.5)	-8.9%
<b>General Fund</b>	<b>\$894.8</b>	<b>\$794.3</b>	<b>(\$100.5)</b>	<b>-11.2%</b>
Other Non-Federal Funds	\$14.3	\$29.5	\$15.2	106.3%

<b>Fiscal Intermediary</b>	<b>FY 2013-14 Appropriation</b>	<b>Nov 2013 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$353.2	\$414.3	\$61.1	17.3%
Federal Funds	\$230.6	\$272.7	\$42.1	18.3%
<b>General Fund</b>	<b>\$122.5</b>	<b>\$141.4</b>	<b>\$18.9</b>	<b>15.4%</b>
Other Non-Federal Funds	\$0.1	\$0.2	\$0.1	100.0%

<b>Total Expenditures</b>	<b>FY 2013-14 Appropriation</b>	<b>Nov 2013 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$69,530.4	\$69,677.7	\$147.4	0.2%
Federal Funds	\$42,675.4	\$43,631.3	\$955.8	2.2%
<b>General Fund</b>	<b>\$16,093.7</b>	<b>\$16,229.9</b>	<b>\$136.2</b>	<b>0.8%</b>
Other Non-Federal Funds	\$10,761.2	\$9,816.7	(\$944.5)	-8.8%

Note: Totals may not add due to rounding.

12/27/2013

The November 2013 Estimate for FY 2013-14 is \$136.2 million General Fund greater than the FY 2013-14 Budget Appropriation.

(In Millions, May Not Add Due to Rounding)

November 2013 General Fund	\$16,229.9
FY 2013-14 Appropriation	<u>\$16,093.7</u>
<b>General Fund Change</b>	<b>\$136.2</b>

This change from the Appropriation is explained as follows:

<b>Medical Care Services</b>	\$217.8
<b>County/Other Administration</b>	-\$100.5
<b>Fiscal Intermediary</b>	\$18.9

The following paragraphs briefly describe the major changes:

**ACA Expansion (PCs 18, 21)**

The ACA Optional and Mandatory Expansions decreased by \$23.1 million from the appropriation in FY 2013-14. There is an increase of \$133.7 million in FY 2014-15. The Optional Expansion was revised to account for additional LIHP caseload and Specialty Mental Health services. Also, the Long Term Services and Support costs which were budgeted separately in the appropriation are now included.

**Other ACA Items (PCs 25, 28, 26, 206, 210)**

The impact of a variety of other ACA items is an increase of \$20.3 million in FY 2013-14 and \$35.9 million in FY 2014-15. These items include Hospital Presumptive Eligibility, Delay of Redeterminations for the months of January through March 2014, Newly Qualified Aliens under ACA, Express Lane Enrollment, and delay of the proposal for shifting pregnant women to Covered California with the Department responsible for out-of-pocket costs and difference in benefits.

**Managed Care Model PCs (Base PCs 114, 115, 116, 132)**

The Estimate increases the three major types of managed care plans by \$93.7 million in FY 2013-14 and \$457.0 million in FY 2014-15. Of the FY 2014-15 increase, \$231.8 million is a placeholder for an estimated 3.63% increase in rates. Also, built into the rates and removed from the relevant policy changes are the impacts of prior long-term care rate increases.

**Coordinated Care Initiative (PCs 143, 119, 197, 123, OA 17)**

General Fund costs in FY 2013-14 are \$29.9 million less than the appropriation and there is an increase of \$158.8 million in FY 2014-15. The changes are a result of delaying phase-in of most eligibles until April 2014 rather than January. In addition to phase-in changes, rates used in the estimate have been adjusted.

### **MCO Tax Managed Care Plans (PC 140)**

The 3.9375% MCO tax benefit to the GF is \$48.1 million less in FY 2013-14 than the appropriation. This reflects delays in the CCI and rural managed care transitions. In FY 2014-15, the benefit to the GF is increased by \$205.9 million.

### **1% FMAP Increase for Preventive Services (PCs 27, 30)**

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. 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. The effective date for receiving the 1% enhanced FMAP changed from January 1, 2014 to January 1, 2013. The changes result in a decrease of \$29.1 million in FY 2013-14 and an increase of \$36.0 million in FY 2014-15.

### **Provider Rate Reductions (PCs 155, 157, 196)**

AB 97 (Chapter 3, Statutes of 2011) enacted provider rate reductions. The Department received the positive solution of the court injunctions in June 2013 and implemented the payment reductions retroactive to June 1, 2011 for the previously enjoined providers in various phases beginning September 2013. Managed care reductions will be implemented prospectively only, effective October 1, 2013. The Estimate also assumes that the Department will take 58 to 72 months to recover the FFS retroactive savings beginning January 2014. Also, in order to ensure access to services, the Department will forgive AB 97 retroactive recoupments for the following: physicians/clinics, high cost pharmacy, dental, intermediate care facilities for the developmentally disabled, and medical transportation. These changes result in an increase of \$295.9 million General Fund in FY 2013-14 and savings of \$120.0 million General Fund in FY 14-15.

### **Hospital Quality Assurance Fee - Children's Health Care (PCs 195, 198)**

The Hospital Quality Assurance Fee (QAF) provides funds for supplemental payments to hospitals and also provides funding to offset the costs of health care coverage for children. SB 335 (Chapter 286, Statutes of 2011) established the Hospital QAF program from July 1, 2011 through December 31, 2013. SB 239 (Chapter 657, Statutes of 2013) extends the Hospital QAF program from January 1, 2014 through December 31, 2016.

Due to timing of QAF collections, \$155.0 million GF savings are shifted from FY 2013-14 to FY 2014-15.

### **Retroactive Managed Care Rate Adjustments (PC 124)**

The retroactive rate adjustments have increased by \$116.6 million in FY 2013-14. This is primarily due to adjustments for the rates for SPD in FY 2011-12 and FY 2012-13.

**Restoration of Selected Adult Dental Benefits (PC 38, OA 24)**

The estimated cost for this change decreases by \$13.3 million in FY 2013-14 and increases by \$75.6 million in FY 2014-15. ACA caseload estimates were updated and a six-month phase-in was included in the November Estimate.

**Drug Rebates (PCs 34, 59, 60, 61)**

Drug Rebates have increased in both years, reflecting recent experience with collections. The added GF savings in FY 2013-14 is \$69.2 million, and \$20.3 million in FY 2014-15.

**General Fund Reimbursement from DPHs (PC 136)**

Reimbursement from the DPHs is now expected to be \$53.1 million less than the appropriation in FY 2013-14 due to a shift in collection of Year 3 payments from FY 2013-14 to FY 2014-15. FY 2014-15 payments are expected to increase by \$12.7 million.

**County Administration (CA 5)**

County Admin costs for Transition of HFP to Medi-Cal increased by \$7.2 million to reflect revised caseload and rollover of prior year funding. FY 2014-15 is reduced by \$4.0 million.

**Enhanced Federal Funding for County Administration (CA 14)**

Federal funding at 75% rather than the usual 50% is available for certain eligibility determination-related costs. The affected costs include application, on-going case maintenance and renewal functions. This will result in a GF savings of \$124.2 million in FY 2013-14 and \$248.4 million in FY 2014-15.

**Payment to Primary Care Physicians (PC 19)**

The Affordable Care Act 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 physician services eligible for the increase payment are exempt from AB 97 (Chapter 3, Statutes of 2011) payment reductions. The Estimate incorporates updated AB 97 savings data. The change results in a decrease of \$89.5 million General Fund in FY 2013-14 and \$6.5 million in FY 2014-15.

**Drug Medi-Cal (PCs 62, 63, 64, 65, 203, OA 58)**

The Enhanced Drug Medi-Cal (DMC) services expenditures are now shown in each of the existing DMC modality policy changes. Also, beginning January 1, 2014, pregnant and postpartum eligibility restrictions will be lifted for Residential Treatment and Intensive Outpatient services beneficiaries making these available to expanded populations. Beginning July 1, 2014, DMC County Administration costs will be reflected in a separate policy change rather than included in the benefits policy changes. A reduction of \$14.7 million TF in FY 2013-14 and FY 2014-15 in DMC expenditures are due to the closure of DMC provider facilities that are suspended as a result of fraudulent Medi-Cal billing practices. GF costs related to the enhanced services increased by \$28.8 million in FY 2013-14 and \$44.3 million in FY 2014-15.

**Women's Health Services (PC 51)**

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. The Department will be reducing or eliminating some services and increasing access to others resulting in a reduction of General Fund costs of \$3.4 million in FY 2013-14 and \$1.1 million in FY 2014-15.

**Managed Care Expansion to Rural Counties (PC 127)**

Changes in implementation dates and revised capitation rates reduced the FY 2013-14 cost by \$70.0 million. The decreased cost in FY 2014-15 is \$18.8 million.

**Mental Health Services Expansion (PC 22)**

The estimate of costs for the incorporation of non-specialty mental health services into managed care plans and the expansion of coverage to include group mental health counseling has been revised to reflect FY 2013-14 capitation rates. This reduces cost in FY 2013-14 by \$3.5 million GF. Costs in FY 2014-15 are \$90.6 million higher; however, this is based upon preliminary rates used as a placeholder.

## November 2013 Medi-Cal Estimate

### Budget Year (FY 2014-15) Projected Expenditures Compared to Current Year (FY 2013-14)

(Dollars in Millions)

Total Medi-Cal local assistance expenditures in the Department of Health Care Services (DHCS) budget in the Budget Year as compared to the Current Year are as follows:

<b>Medical Care Services</b>	<b>FY 2013-14 Estimate</b>	<b>FY 2014-15 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$65,641.0	\$69,725.3	\$4,084.3	6.2%
Federal Funds	\$40,559.8	\$42,776.4	\$2,216.6	5.5%
<b>General Fund</b>	<b>\$15,294.2</b>	<b>\$16,123.4</b>	<b>\$829.2</b>	<b>5.4%</b>
Other Non-Federal Funds	\$9,787.0	\$10,825.5	\$1,038.5	10.6%

<b>County Administration</b>	<b>FY 2013-14 Estimate</b>	<b>FY 2014-15 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$3,622.5	\$3,361.9	(\$260.6)	-7.2%
Federal Funds	\$2,798.7	\$2,684.1	(\$114.6)	-4.1%
<b>General Fund</b>	<b>\$794.3</b>	<b>\$648.9</b>	<b>(\$145.4)</b>	<b>-18.3%</b>
Other Non-Federal Funds	\$29.5	\$28.9	(\$0.6)	-2.0%

<b>Fiscal Intermediary</b>	<b>FY 2013-14 Estimate</b>	<b>FY 2014-15 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$414.3	\$419.3	\$5.0	1.2%
Federal Funds	\$272.7	\$292.0	\$19.3	7.1%
<b>General Fund</b>	<b>\$141.4</b>	<b>\$127.2</b>	<b>(\$14.2)</b>	<b>-10.0%</b>
Other Non-Federal Funds	\$0.2	\$0.1	(\$0.1)	-50.0%

<b>Total Expenditures</b>	<b>FY 2013-14 Estimate</b>	<b>FY 2014-15 Estimate</b>	<b>Change</b>	
			<b>Amount</b>	<b>Percent</b>
Total Funds	\$69,677.7	\$73,506.4	\$3,828.7	5.5%
Federal Funds	\$43,631.3	\$45,752.5	\$2,121.3	4.9%
<b>General Fund</b>	<b>\$16,229.9</b>	<b>\$16,899.5</b>	<b>\$669.6</b>	<b>4.1%</b>
Other Non-Federal Funds	\$9,816.7	\$10,854.5	\$1,037.8	10.6%

Note: Totals may not add due to rounding.

12/27/2013

The Medi-Cal General Fund costs in FY 2014-15, as compared to FY 2013-14, are estimated in increase by \$669.6 million, an increase of approximately four percent.

(In Millions, May Not Add Due to Rounding)

FY 2013-14	\$16,229.9
FY 2014-15	<u>\$16,899.5</u>
<b>General Fund Change</b>	<b>\$669.6</b>

This change from the FY 2013-14 to FY 2014-15 is explained as follows:

<b><i>Medical Care Services</i></b>	\$829.2
<b><i>County/Other Administration</i></b>	-\$145.4
<b><i>Fiscal Intermediary</i></b>	-\$14.2

The following paragraphs briefly describe the major changes that were not discussed above under the FY 2013-14 Current Year:

**Health Insurer Fee (PC 205)**

The ACA imposes an excise tax on certain health insurers, effective January 1, 2014. This policy change estimates the increase in rates that will be paid to affected plans. The estimated FY 2014-15 cost is \$54.6 million, which will cover FY 2013-14 and FY 2014-15.

**County Administration (PCs CA 3, CA 9, CA 12)**

County Administration costs for FY 2014-15 decreased by \$13.8 million Total Fund. The cost for the implementation of ACA in FY 2013-14 is reduced in FY 2014-15 by the one-time costs associated with training, planning and development. The additional funding associated with processing new applications and redeterminations continues in FY 2014-15 at \$130.1 million Total Funds. Eligible growth and the Cost of Living Adjustment are not funded in FY 2014-15.

**MCO Supplemental Drug Rebates (PC 211)**

State supplemental drug rebates would be applied to outpatient managed care organization drug utilization. This is estimated to save \$32.5 million in FY 2014-15.

General Information

This estimate is based on actual payment data through August 2013. Estimates for both fiscal years are on a cash basis.

The Medi-Cal Program has many funding sources. These funding sources are shown by budget item number on the State Funds and Federal Funds pages of the Medi-Cal Funding Summary in the Management Summary tab. The budget items which are made up of State General Fund are identified with an asterisk and are shown in separate totals. Healthy Families (Title XXI) costs incurred by the Department are included in the Estimate and are separately identified under item number 4260-113. Reimbursements include Refugees (CDPH), MSSP (CDA), Dental Services (CDSS), Managed Care IGTs, IGTs for Non-SB 1100 Hospitals, IMD Ancillary Services (DMH) and IHSS costs (CDSS).

The Miscellaneous Non-Fee-For-Service Category includes expenditures for Home and Community Based Services -- DDS, Case Management Services -- DDS, Personal Care Services, HIPP premiums, Targeted Case Management, and Hospital Financing—Health Care Coverage Initiative.

The estimate aggregates expenditures for four sub-categories under a single Managed Care heading. These sub-categories are Two Plan Model, County Organized Health Systems, Geographic Managed Care, and PHP/Other Managed Care. The latter includes PCCMs, PACE, SCAN, Family Mosaic, Dental Managed Care, and the new Managed Care Expansion models – Regional, Imperial, and San Benito.

Should a projected deficiency exist, Section 14157.6 of the Welfare and Institutions Codes authorizes appropriation, subject to 30-day notification to the Legislature, of any federal or county funds received for expenditures in prior years. At this time, no prior year General Funds have been identified to be included in the above estimates as abatements against current year costs.

There is considerable uncertainty associated with projecting Medi-Cal expenditures for medical care services, which vary according to the number of persons eligible for Medi-Cal, the number and type of services these people receive, and the cost of providing these services. Additional uncertainty is created by monthly fluctuations in claims processing, federal audit exceptions, and uncertainties in the implementation dates for policy changes which often require approval of federal waivers or state plan amendments, changes in regulations, and in some cases, changes in the adjudication process at the fiscal intermediary.

Provider payment reductions, injunctions, and restorations add to this uncertainty as it disturbs the regular flow of the FI checkwrite payments. It is assumed that estimated expenditures may vary due to this uncertainty. A 1% variation in total Medi-Cal Benefits expenditures would result in a \$697 million TF (\$162 million General Funds) change in expenditures in FY 2013-14 and \$735 million TF (\$169 million General Funds) in FY 2014-15.

**Medi-Cal Funding Summary**  
**November 2013 Estimate Compared to Appropriation**  
**Fiscal Year 2013 - 2014**

**TOTAL FUNDS**

	<u>Total Appropriation</u>	<u>Nov 2013 Estimate</u>	<u>Difference Incr./(Decr.)</u>
<b><u>MEDI-CAL Benefits:</u></b>			
4260-101-0001/0890(3)	\$50,771,860,000	\$51,851,973,000	\$1,080,113,000
4260-101-0080 CLPP Funds	\$130,000	\$714,000	\$584,000
4260-101-0232 Prop. 99 Hospital Svcs. Acct.	\$58,946,000	\$58,946,000	\$0
4260-101-0233 Prop. 99 Physician Svcs. Acct.	\$105,000	\$105,000	\$0
4260-101-0236 Prop. 99 Unallocated Account	\$23,540,000	\$23,540,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$11,429,000	\$11,537,000	\$108,000
4260-101-3213 LTC QA Fund	\$436,646,000	\$439,445,000	\$2,799,000
4260-102-0001/0890 Capital Debt	\$92,086,000	\$97,380,000	\$5,294,000
4260-104-0001 NDPH Hosp Supp *	\$3,531,000	\$3,531,000	\$0
4260-601-3096 NDPH Suppl	\$3,802,000	\$4,255,000	\$453,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$3,531,000)	(\$3,531,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$77,360,000	\$77,360,000	\$0
4260-601-3097 Private Hosp Suppl	\$128,595,000	\$124,301,000	(\$4,294,000)
4260-698-3097 Private Hosp Suppl (Less Funded by GF)	(\$77,360,000)	(\$77,360,000)	\$0
4260-106-0890 Money Follow Person Federal Grant	\$33,080,000	\$52,745,000	\$19,665,000
4260-113-0001/0890 Healthy Families	\$1,761,373,000	\$1,853,963,000	\$92,590,000
4260-113-3055 County Health Initiative Matching Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$41,000,000	\$50,000,000	\$9,000,000
4260-601-3156 MCO Tax Fund	\$849,078,000	\$829,102,000	(\$19,976,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$772,646,000	\$797,824,000	\$25,178,000
4260-601-7502 Demonstration DSH Fund	\$520,264,000	\$893,842,000	\$373,578,000
4260-601-7503 Health Care Support Fund	\$1,163,739,000	\$998,652,000	(\$165,087,000)
4260-602-0309 Perinatal Insurance Fund	\$0	\$0	\$0
4260-605-0001 SNF Quality & Accountability *	\$26,756,000	\$24,552,000	(\$2,204,000)
4260-605-3167 SNF Quality & Accountability	\$20,701,000	\$20,337,000	(\$364,000)
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	(\$26,756,000)	(\$24,552,000)	\$2,204,000
4260-606-0834 SB 1100 DSH	\$662,764,000	\$394,037,000	(\$268,727,000)
4260-607-8502 Low Income Health Program IGT	\$2,104,001,000	\$2,383,690,000	\$279,689,000
4260-610-0995 Reimbursements	\$1,602,811,000	\$903,077,000	(\$699,734,000)
4260-610-3158 Hospital Quality Assurance Revenue	\$1,000,000	\$525,000	(\$475,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	\$33,200,000	\$0	(\$33,200,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$4,104,084,000	\$3,851,018,000	(\$253,066,000)
<b>TOTAL MEDI-CAL Benefits</b>	<b><u>\$65,196,880,000</u></b>	<b><u>\$65,641,008,000</u></b>	<b><u>\$444,128,000</u></b>
<b><u>COUNTY ADMINISTRATION:</u></b>			
4260-101-0001/0890(1)	\$3,866,732,000	\$3,456,342,000	(\$410,390,000)
4260-106-0890(1) Money Follow Person Fed. Grant	\$727,000	\$485,000	(\$242,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	\$2,500,000	\$2,835,000	\$335,000
4260-113-0001/0890 Healthy Families	\$92,556,000	\$116,617,000	\$24,061,000
4260-117-0001/0890 HIPAA	\$3,452,000	\$3,468,000	\$16,000
4260-605-3167 SNF Quality & Accountability Admin.	\$2,433,000	\$2,780,000	\$347,000
4260-608-0942/0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$0	\$26,500,000	\$26,500,000
4260-610-0995 Reimbursements	\$11,903,000	\$13,458,000	\$1,555,000
<b>TOTAL COUNTY ADMIN.</b>	<b><u>\$3,980,303,000</u></b>	<b><u>\$3,622,485,000</u></b>	<b><u>(\$357,818,000)</u></b>
<b><u>FISCAL INTERMEDIARY:</u></b>			
4260-101-0001/0890(2)	\$325,979,000	\$365,790,000	\$39,811,000
4260-113-0001/0890 Healthy Families	\$868,000	\$26,648,000	\$25,780,000
4260-117-0001/0890 HIPAA	\$25,749,000	\$21,699,000	(\$4,050,000)
4260-601-0001 100% General Fund	\$500,000	\$0	(\$500,000)
4260-610-0995 Reimbursements	\$101,000	\$115,000	\$14,000
<b>TOTAL FISCAL INTERMEDIARY</b>	<b><u>\$353,197,000</u></b>	<b><u>\$414,252,000</u></b>	<b><u>\$61,055,000</u></b>
<b>GRAND TOTAL - ALL FUNDS</b>	<b><u>\$69,530,380,000</u></b>	<b><u>\$69,677,745,000</u></b>	<b><u>\$147,365,000</u></b>

Note: Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

**Medi-Cal Funding Summary**  
**November 2013 Estimate Compared to Appropriation**  
**Fiscal Year 2013 - 2014**

**STATE FUNDS**

	<b>State Funds Appropriation</b>	<b>Nov 2013 Estimate</b>	<b>Difference Incr./(Decr.)</b>
<b><u>MEDI-CAL Benefits:</u></b>			
4260-101-0001(3) *	\$14,355,054,000	\$14,540,449,000	\$185,395,000
4260-101-0080 CLPP Funds	\$130,000	\$714,000	\$584,000
4260-101-0232 Prop. 99 Hospital Svcs. Acct.	\$58,946,000	\$58,946,000	\$0
4260-101-0233 Prop. 99 Physician Svcs. Acct.	\$105,000	\$105,000	\$0
4260-101-0236 Prop. 99 Unallocated Account	\$23,540,000	\$23,540,000	\$0
4260-101-3168 Emergency Air Transportation Fund	\$11,429,000	\$11,537,000	\$108,000
4260-101-3213 LTC QA Fund	\$436,646,000	\$439,445,000	\$2,799,000
4260-102-0001 Capital Debt *	\$46,043,000	\$48,690,000	\$2,647,000
4260-104-0001 NDPH Hosp Supp *	\$3,531,000	\$3,531,000	\$0
4260-601-3096 NDPH Suppl	\$3,802,000	\$4,255,000	\$453,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$3,531,000)	(\$3,531,000)	\$0
4260-105-0001 Private Hosp Supp Fund *	\$77,360,000	\$77,360,000	\$0
4260-601-3097 Private Hosp Suppl	\$128,595,000	\$124,301,000	(\$4,294,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$77,360,000)	(\$77,360,000)	\$0
4260-113-0001 Healthy Families *	\$567,616,000	\$599,589,000	\$31,973,000
4260-113-3055 County Health Initiative Matching Fund	\$0	\$0	\$0
4260-601-0942142 Local Trauma Centers	\$41,000,000	\$50,000,000	\$9,000,000
4260-601-3156 MCO Tax Fund	\$849,078,000	\$829,102,000	(\$19,976,000)
4260-601-3158 Hosp. Quality Assurance Revenue	\$0	\$0	\$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$772,646,000	\$797,824,000	\$25,178,000
4260-602-0309 Perinatal Insurance Fund	\$0	\$0	\$0
4260-605-0001 SNF Quality & Accountability *	\$26,756,000	\$24,552,000	(\$2,204,000)
4260-605-3167 SNF Quality & Accountability	\$20,701,000	\$20,337,000	(\$364,000)
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	(\$26,756,000)	(\$24,552,000)	\$2,204,000
4260-606-0834 SB 1100 DSH	\$662,764,000	\$394,037,000	(\$268,727,000)
4260-607-8502 Low Income Health Program IGT	\$2,104,001,000	\$2,383,690,000	\$279,689,000
4260-610-0995 Reimbursements	\$1,602,811,000	\$903,077,000	(\$699,734,000)
4260-610-3158 Hospital Quality Assurance Revenue	\$1,000,000	\$525,000	(\$475,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	\$33,200,000	\$0	(\$33,200,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$4,104,084,000	\$3,851,018,000	(\$253,066,000)
<b>TOTAL MEDI-CAL Benefits</b>	<b>\$25,823,191,000</b>	<b>\$25,081,181,000</b>	<b>(\$742,010,000)</b>
<b>Total Benefits General Fund *</b>	<b>\$15,076,360,000</b>	<b>\$15,294,171,000</b>	<b>\$217,811,000</b>
<b><u>COUNTY ADMINISTRATION:</u></b>			
4260-101-0001(1) *	\$866,567,000	\$758,388,000	(\$108,179,000)
4260-113-0001 Healthy Families *	\$27,738,000	\$35,406,000	\$7,668,000
4260-117-0001 HIPAA *	\$500,000	\$504,000	\$4,000
4260-605-3167 SNF Quality & Accountability Admin.	\$2,433,000	\$2,780,000	\$347,000
4260-608-0942 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$0	\$13,250,000	\$13,250,000
4260-610-0995 Reimbursements	\$11,903,000	\$13,458,000	\$1,555,000
<b>TOTAL COUNTY ADMIN.</b>	<b>\$909,141,000</b>	<b>\$823,786,000</b>	<b>(\$85,355,000)</b>
<b>Total Co. Admin. General Fund *</b>	<b>\$894,805,000</b>	<b>\$794,298,000</b>	<b>(\$107,828,000)</b>
<b><u>FISCAL INTERMEDIARY:</u></b>			
4260-101-0001(2) *	\$117,382,000	\$128,149,000	\$10,767,000
4260-113-0001 Healthy Families *	\$304,000	\$9,327,000	\$9,023,000
4260-117-0001 HIPAA *	\$4,347,000	\$3,935,000	(\$412,000)
4260-601-0001 100% General Fund *	\$500,000	\$0	(\$500,000)
4260-610-0995 Reimbursements	\$101,000	\$115,000	\$14,000
<b>TOTAL FISCAL INTERMEDIARY</b>	<b>\$122,634,000</b>	<b>\$141,526,000</b>	<b>\$18,892,000</b>
<b>Total FI General Fund *</b>	<b>\$122,533,000</b>	<b>\$141,411,000</b>	<b>\$18,878,000</b>
<b>GRAND TOTAL - STATE FUNDS</b>	<b>\$26,854,966,000</b>	<b>\$26,046,493,000</b>	<b>(\$808,473,000)</b>
<b>Grand Total - General Fund *</b>	<b>\$16,093,698,000</b>	<b>\$16,229,880,000</b>	<b>\$136,182,000</b>

Note: Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

**Medi-Cal Funding Summary**  
**November 2013 Estimate Compared to Appropriation**  
**Fiscal Year 2013 - 2014**

**FEDERAL FUNDS**

	<b>Federal Funds Appropriation</b>	<b>Nov 2013 Estimate</b>	<b>Difference Incr./(Decr.)</b>
<b><u>MEDI-CAL Benefits:</u></b>			
4260-101-0890(3)	\$36,416,806,000	\$37,311,524,000	\$894,718,000
4260-102-0890 Capital Debt	\$46,043,000	\$48,690,000	\$2,647,000
4260-106-0890 Money Follow Person Federal Grant	\$33,080,000	\$52,745,000	\$19,665,000
4260-113-0890 Healthy Families	\$1,193,757,000	\$1,254,374,000	\$60,617,000
4260-601-7502 Demonstration DSH Fund	\$520,264,000	\$893,842,000	\$373,578,000
4260-601-7503 Health Care Support Fund	\$1,163,739,000	\$998,652,000	(\$165,087,000)
<b>TOTAL MEDI-CAL Benefits</b>	<b><u>\$39,373,689,000</u></b>	<b><u>\$40,559,827,000</u></b>	<b><u>\$1,186,138,000</u></b>
<b><u>COUNTY ADMINISTRATION:</u></b>			
4260-101-0890(1)	\$3,000,165,000	\$2,697,954,000	(\$302,211,000)
4260-106-0890(1) Money Follow Person Fed. Grant	\$727,000	\$485,000	(\$242,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	\$2,500,000	\$2,835,000	\$335,000
4260-113-0890 Healthy Families	\$64,818,000	\$81,211,000	\$16,393,000
4260-117-0890 HIPAA	\$2,952,000	\$2,964,000	\$12,000
4260-608-0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$0	\$13,250,000	\$13,250,000
<b>TOTAL COUNTY ADMIN.</b>	<b><u>\$3,071,162,000</u></b>	<b><u>\$2,798,699,000</u></b>	<b><u>(\$272,463,000)</u></b>
<b><u>FISCAL INTERMEDIARY:</u></b>			
4260-101-0890(2)	\$208,597,000	\$237,641,000	\$29,044,000
4260-113-0890 Healthy Families	\$564,000	\$17,321,000	\$16,757,000
4260-117-0890 HIPAA	\$21,402,000	\$17,764,000	(\$3,638,000)
<b>TOTAL FISCAL INTERMEDIARY</b>	<b><u>\$230,563,000</u></b>	<b><u>\$272,726,000</u></b>	<b><u>\$42,163,000</u></b>
 <b>GRAND TOTAL - FEDERAL FUNDS</b>	 <b><u>\$42,675,414,000</u></b>	 <b><u>\$43,631,252,000</u></b>	 <b><u>\$955,838,000</u></b>

**Medi-Cal Funding Summary**  
**November 2013 Estimate Comparison of FY 2013-14 to FY 2014-15**

**TOTAL FUNDS**

	<u>FY 2013-14</u> <u>Estimate</u>	<u>FY 2014-15</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./(Decr.)</u>
<b>MEDI-CAL Benefits:</b>			
4260-101-0001/0890(3)	\$51,851,973,000	\$55,278,973,000	\$3,427,000,000
4260-101-0080 CLPP Funds	\$714,000	\$714,000	\$0
4260-101-0232 Prop. 99 Hospital Svcs. Acct.	\$58,946,000	\$72,435,000	\$13,489,000
4260-101-0233 Prop. 99 Physician Svcs. Acct.	\$105,000	\$105,000	\$0
4260-101-0236 Prop. 99 Unallocated Account	\$23,540,000	\$26,991,000	\$3,451,000
4260-101-3168 Emergency Air Transportation Fund	\$11,537,000	\$9,133,000	(\$2,404,000)
4260-101-3213 LTC QA Fund	\$439,445,000	\$470,374,000	\$30,929,000
4260-102-0001/0890 Capital Debt	\$97,380,000	\$90,422,000	(\$6,958,000)
4260-104-0001 NDPH Hosp Supp *	\$3,531,000	\$1,900,000	(\$1,631,000)
4260-601-3096 NDPH Suppl	\$4,255,000	\$1,901,000	(\$2,354,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$3,531,000)	(\$1,900,000)	\$1,631,000
4260-105-0001 Private Hosp Supp Fund *	\$77,360,000	\$118,400,000	\$41,040,000
4260-601-3097 Private Hosp Suppl	\$124,301,000	\$121,501,000	(\$2,800,000)
4260-698-3097 Private Hosp Suppl (Less Funded by GF)	(\$77,360,000)	(\$118,400,000)	(\$41,040,000)
4260-106-0890 Money Follow Person Federal Grant	\$52,745,000	\$25,528,000	(\$27,217,000)
4260-113-0001/0890 Healthy Families	\$1,853,963,000	\$2,069,468,000	\$215,505,000
4260-113-3055 County Health Initiative Matching Fund	\$0	\$509,000	\$509,000
4260-601-0942142 Local Trauma Centers	\$50,000,000	\$35,000,000	(\$15,000,000)
4260-601-3156 MCO Tax Fund	\$829,102,000	\$1,172,397,000	\$343,295,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$797,824,000	\$946,155,000	\$148,331,000
4260-601-7502 Demonstration DSH Fund	\$893,842,000	\$613,331,000	(\$280,511,000)
4260-601-7503 Health Care Support Fund	\$998,652,000	\$676,618,000	(\$322,034,000)
4260-602-0309 Perinatal Insurance Fund	\$0	\$57,459,000	\$57,459,000
4260-605-0001 SNF Quality & Accountability *	\$24,552,000	\$25,161,000	\$609,000
4260-605-3167 SNF Quality & Accountability	\$20,337,000	\$21,329,000	\$992,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	(\$24,552,000)	(\$25,161,000)	(\$609,000)
4260-606-0834 SB 1100 DSH	\$394,037,000	\$548,529,000	\$154,492,000
4260-607-8502 Low Income Health Program IGT	\$2,383,690,000	\$0	(\$2,383,690,000)
4260-610-0995 Reimbursements	\$903,077,000	\$3,233,332,000	\$2,330,255,000
4260-610-3158 Hospital Quality Assurance Revenue	\$525,000	\$0	(\$525,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$3,851,018,000	\$4,253,059,000	\$402,041,000
<b>TOTAL MEDI-CAL Benefits</b>	<b><u>\$65,641,008,000</u></b>	<b><u>\$69,725,263,000</u></b>	<b><u>\$4,084,255,000</u></b>
<b>COUNTY ADMINISTRATION:</b>			
4260-101-0001/0890(1)	\$3,456,342,000	\$3,216,922,000	(\$239,420,000)
4260-106-0890(1) Money Follow Person Fed. Grant	\$485,000	\$648,000	\$163,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	\$2,835,000	\$2,660,000	(\$175,000)
4260-113-0001/0890 Healthy Families	\$116,617,000	\$95,652,000	(\$20,965,000)
4260-117-0001/0890 HIPAA	\$3,468,000	\$3,939,000	\$471,000
4260-605-3167 SNF Quality & Accountability Admin.	\$2,780,000	\$2,533,000	(\$247,000)
4260-608-0942/0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$26,500,000	\$26,500,000	\$0
4260-610-0995 Reimbursements	\$13,458,000	\$13,058,000	(\$400,000)
<b>TOTAL COUNTY ADMIN.</b>	<b><u>\$3,622,485,000</u></b>	<b><u>\$3,361,912,000</u></b>	<b><u>(\$260,573,000)</u></b>
<b>FISCAL INTERMEDIARY:</b>			
4260-101-0001/0890(2)	\$365,790,000	\$376,850,000	\$11,060,000
4260-113-0001/0890 Healthy Families	\$26,648,000	\$19,787,000	(\$6,861,000)
4260-117-0001/0890 HIPAA	\$21,699,000	\$22,500,000	\$801,000
4260-610-0995 Reimbursements	\$115,000	\$134,000	\$19,000
<b>TOTAL FISCAL INTERMEDIARY</b>	<b><u>\$414,252,000</u></b>	<b><u>\$419,271,000</u></b>	<b><u>\$5,019,000</u></b>
<b>GRAND TOTAL - ALL FUNDS</b>	<b><u>\$69,677,745,000</u></b>	<b><u>\$73,506,446,000</u></b>	<b><u>\$3,828,701,000</u></b>

Notes: Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

**Medi-Cal Funding Summary**  
**November 2013 Estimate Comparison of FY 2013-14 to FY 2014-15**

**STATE FUNDS**

	<u>FY 2013-14</u> <u>Estimate</u>	<u>FY 2014-15</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./(Decr.)</u>
<b>MEDI-CAL Benefits:</b>			
4260-101-0001(3) *	\$14,540,449,000	\$15,296,450,000	\$756,001,000
4260-101-0080 CLPP Funds	\$714,000	\$714,000	\$0
4260-101-0232 Prop. 99 Hospital Svcs. Acct.	\$58,946,000	\$72,435,000	\$13,489,000
4260-101-0233 Prop. 99 Physician Svcs. Acct.	\$105,000	\$105,000	\$0
4260-101-0236 Prop. 99 Unallocated Account	\$23,540,000	\$26,991,000	\$3,451,000
4260-101-3168 Emergency Air Transportation Fund	\$11,537,000	\$9,133,000	(\$2,404,000)
4260-101-3213 LTC QA Fund	\$439,445,000	\$470,374,000	\$30,929,000
4260-102-0001 Capital Debt *	\$48,690,000	\$45,211,000	(\$3,479,000)
4260-104-0001 NDPH Hosp Supp *	\$3,531,000	\$1,900,000	(\$1,631,000)
4260-601-3096 NDPH Suppl	\$4,255,000	\$1,901,000	(\$2,354,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	(\$3,531,000)	(\$1,900,000)	\$1,631,000
4260-105-0001 Private Hosp Supp Fund *	\$77,360,000	\$118,400,000	\$41,040,000
4260-601-3097 Private Hosp Suppl	\$124,301,000	\$121,501,000	(\$2,800,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	(\$77,360,000)	(\$118,400,000)	(\$41,040,000)
4260-113-0001 Healthy Families *	\$599,589,000	\$636,254,000	\$36,665,000
4260-113-3055 County Health Initiative Matching Fund	\$0	\$509,000	\$509,000
4260-601-0942142 Local Trauma Centers	\$50,000,000	\$35,000,000	(\$15,000,000)
4260-601-3156 MCO Tax Fund	\$829,102,000	\$1,172,397,000	\$343,295,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	\$797,824,000	\$946,155,000	\$148,331,000
4260-602-0309 Perinatal Insurance Fund	\$0	\$57,459,000	\$57,459,000
4260-605-0001 SNF Quality & Accountability *	\$24,552,000	\$25,161,000	\$609,000
4260-605-3167 SNF Quality & Accountability	\$20,337,000	\$21,329,000	\$992,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	(\$24,552,000)	(\$25,161,000)	(\$609,000)
4260-606-0834 SB 1100 DSH	\$394,037,000	\$548,529,000	\$154,492,000
4260-607-8502 Low Income Health Program IGT	\$2,383,690,000	\$0	(\$2,383,690,000)
4260-610-0995 Reimbursements	\$903,077,000	\$3,233,332,000	\$2,330,255,000
4260-610-3158 Hospital Quality Assurance Revenue	\$525,000	\$0	(\$525,000)
4260-611-3158 Hospital Quality Assurance Revenue	\$3,851,018,000	\$4,253,059,000	\$402,041,000
<b>TOTAL MEDI-CAL Benefits</b>	<b>\$25,081,181,000</b>	<b>\$26,948,838,000</b>	<b>\$1,867,657,000</b>
<b>Total Benefits General Fund *</b>	<b>\$15,294,171,000</b>	<b>\$16,123,376,000</b>	<b>\$829,205,000</b>
<b>COUNTY ADMINISTRATION:</b>			
4260-101-0001(1) *	\$758,388,000	\$619,225,000	(\$139,163,000)
4260-113-0001 Healthy Families *	\$35,406,000	\$29,099,000	(\$6,307,000)
4260-117-0001 HIPAA *	\$504,000	\$622,000	\$118,000
4260-605-3167 SNF Quality & Accountability Admin.	\$2,780,000	\$2,533,000	(\$247,000)
4260-608-0942 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$13,250,000	\$13,250,000	\$0
4260-610-0995 Reimbursements	\$13,458,000	\$13,058,000	(\$400,000)
<b>TOTAL COUNTY ADMIN.</b>	<b>\$823,786,000</b>	<b>\$677,787,000</b>	<b>(\$145,999,000)</b>
<b>Total Co. Admin. General Fund *</b>	<b>\$794,298,000</b>	<b>\$648,946,000</b>	<b>(\$145,352,000)</b>
<b>FISCAL INTERMEDIARY:</b>			
4260-101-0001(2) *	\$128,149,000	\$117,531,000	(\$10,618,000)
4260-113-0001 Healthy Families *	\$9,327,000	\$6,925,000	(\$2,402,000)
4260-117-0001 HIPAA *	\$3,935,000	\$2,717,000	(\$1,218,000)
4260-601-0001 100% General Fund *	\$0	\$0	\$0
4260-610-0995 Reimbursements	\$115,000	\$134,000	\$19,000
<b>TOTAL FISCAL INTERMEDIARY</b>	<b>\$141,526,000</b>	<b>\$127,307,000</b>	<b>(\$14,219,000)</b>
<b>Total FI General Fund *</b>	<b>\$141,411,000</b>	<b>\$127,173,000</b>	<b>(\$14,238,000)</b>
<b>GRAND TOTAL - STATE FUNDS</b>	<b>\$26,046,493,000</b>	<b>\$27,753,932,000</b>	<b>\$1,707,439,000</b>
<b>Grand Total General Fund *</b>	<b>\$16,229,880,000</b>	<b>\$16,899,495,000</b>	<b>\$669,615,000</b>

Notes: Proposition 99 funding is from the Cigarette and Tobacco Products Surtax Fund accounts as shown above.

**Medi-Cal Funding Summary**  
**November 2013 Estimate Comparison of FY 2013-14 to FY 2014-15**

**FEDERAL FUNDS**

	<u>FY 2013-14</u> <u>Estimate</u>	<u>FY 2014-15</u> <u>Estimate</u>	<u>Difference</u> <u>Incr./.(Decr.)</u>
<b><u>MEDI-CAL Benefits:</u></b>			
4260-101-0890(3)	\$37,311,524,000	\$39,982,523,000	\$2,670,999,000
4260-102-0890 Capital Debt	\$48,690,000	\$45,211,000	(\$3,479,000)
4260-106-0890 Money Follow Person Federal Grant	\$52,745,000	\$25,528,000	(\$27,217,000)
4260-113-0890 Healthy Families	\$1,254,374,000	\$1,433,214,000	\$178,840,000
4260-601-7502 Demonstration DSH Fund	\$893,842,000	\$613,331,000	(\$280,511,000)
4260-601-7503 Health Care Support Fund	\$998,652,000	\$676,618,000	(\$322,034,000)
<b>TOTAL MEDI-CAL Benefits</b>	<b><u>\$40,559,827,000</u></b>	<b><u>\$42,776,425,000</u></b>	<b><u>\$2,216,598,000</u></b>
<b><u>COUNTY ADMINISTRATION:</u></b>			
4260-101-0890(1)	\$2,697,954,000	\$2,597,697,000	(\$100,257,000)
4260-106-0890(1) Money Follow Person Fed. Grant	\$485,000	\$648,000	\$163,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	\$2,835,000	\$2,660,000	(\$175,000)
4260-113-0890 Healthy Families	\$81,211,000	\$66,553,000	(\$14,658,000)
4260-117-0890 HIPAA	\$2,964,000	\$3,317,000	\$353,000
4260-608-0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	\$13,250,000	\$13,250,000	\$0
<b>TOTAL COUNTY ADMIN.</b>	<b><u>\$2,798,699,000</u></b>	<b><u>\$2,684,125,000</u></b>	<b><u>(\$114,574,000)</u></b>
<b><u>FISCAL INTERMEDIARY:</u></b>			
4260-101-0890(2)	\$237,641,000	\$259,319,000	\$21,678,000
4260-113-0890 Healthy Families	\$17,321,000	\$12,862,000	(\$4,459,000)
4260-117-0890 HIPAA	\$17,764,000	\$19,783,000	\$2,019,000
<b>TOTAL FISCAL INTERMEDIARY</b>	<b><u>\$272,726,000</u></b>	<b><u>\$291,964,000</u></b>	<b><u>\$19,238,000</u></b>
 <b>GRAND TOTAL - FEDERAL FUNDS</b>	 <b><u>\$43,631,252,000</u></b>	 <b><u>\$45,752,514,000</u></b>	 <b><u>\$2,121,262,000</u></b>

## MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2013-14

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b>I. BASE ESTIMATES</b>			
A. C/Y FFS BASE	\$15,985,204,310	\$7,992,602,150	\$7,992,602,150
B. C/Y BASE POLICY CHANGES	\$22,774,586,000	\$13,458,950,200	\$9,315,635,800
C. BASE ADJUSTMENTS	-\$143,342,000	-\$212,399,100	\$69,057,100
D. ADJUSTED BASE	<u>\$38,616,448,300</u>	<u>\$21,239,153,250</u>	<u>\$17,377,295,050</u>
<b>II. REGULAR POLICY CHANGES</b>			
A. ELIGIBILITY	\$2,046,577,850	\$1,385,040,980	\$661,536,880
B. AFFORDABLE CARE ACT	\$4,504,962,180	\$4,572,959,390	-\$67,997,210
C. BENEFITS	\$485,713,010	\$540,836,310	-\$55,123,300
D. PHARMACY	-\$1,835,334,000	-\$968,156,150	-\$867,177,850
E. DRUG MEDI-CAL	\$12,504,000	\$8,474,000	\$4,030,000
F. MENTAL HEALTH	\$459,749,000	\$430,768,000	\$28,981,000
G. WAIVER--MH/UCD & BTR	\$10,473,013,540	\$7,311,280,770	\$3,161,732,770
H. MANAGED CARE	\$2,754,943,000	\$1,418,370,000	\$1,336,573,000
I. PROVIDER RATES	\$74,910,990	\$37,455,500	\$37,455,500
J. SUPPLEMENTAL PMNTS.	\$7,810,071,000	\$4,372,588,500	\$3,437,482,500
K. OTHER	\$237,448,000	\$211,056,000	\$26,392,000
L. TOTAL CHANGES	<u>\$27,024,558,570</u>	<u>\$19,320,673,290</u>	<u>\$7,703,885,280</u>
<b>III. TOTAL MEDI-CAL ESTIMATE</b>	<u><u>\$65,641,006,870</u></u>	<u><u>\$40,559,826,540</u></u>	<u><u>\$25,081,180,330</u></u>

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>				
1	TRANSITION OF HFP TO MEDI-CAL	\$1,195,670,000	\$777,185,500	\$418,484,500
2	FAMILY PACT PROGRAM	\$632,717,000	\$474,242,100	\$158,474,900
3	BREAST AND CERVICAL CANCER TREATMENT	\$154,126,000	\$86,461,550	\$67,664,450
4	AIM LINKED INFANTS 250-300% FPL	\$33,357,000	\$21,682,050	\$11,674,950
5	MEDI-CAL ADULT INMATE PROGRAMS	\$12,557,000	\$12,557,000	\$0
6	CHDP GATEWAY - PREENROLLMENT	\$11,937,000	\$7,759,050	\$4,177,950
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM	\$6,467,000	\$6,467,000	\$0
8	REFUGEES	\$5,887,000	\$0	\$5,887,000
9	MCHA VS. DHCS AND MRMIB	\$181,010	\$90,500	\$90,500
11	NEW QUALIFIED IMMIGRANTS	\$0	-\$63,554,000	\$63,554,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	\$56,409,300	-\$56,409,300
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	\$8,901,500	-\$8,901,500
14	INCARCERATION VERIFICATION PROGRAM	-\$136,200	-\$68,100	-\$68,100
15	PARIS-FEDERAL	-\$610,720	-\$305,360	-\$305,360
16	PARIS-VETERANS	-\$2,289,170	-\$1,144,590	-\$1,144,590
17	PARIS-INTERSTATE	-\$3,285,060	-\$1,642,530	-\$1,642,530
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$2,046,577,850</b>	<b>\$1,385,040,970</b>	<b>\$661,536,880</b>
<b>AFFORDABLE CARE ACT</b>				
18	ACA OPTIONAL EXPANSION	\$2,609,318,000	\$2,609,318,000	\$0
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$1,661,805,710	\$1,628,134,750	\$33,670,960
20	COMMUNITY FIRST CHOICE OPTION	\$238,923,000	\$238,923,000	\$0
21	ACA MANDATORY EXPANSION	\$222,825,000	\$119,070,650	\$103,754,350
22	MENTAL HEALTH SERVICES EXPANSION	\$73,695,000	\$45,268,000	\$28,427,000
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COS	\$24,252,000	\$24,252,000	\$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$18,672,000	\$9,503,500	\$9,168,500
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	\$14,493,000	\$9,239,000	\$5,254,000
27	USPSTF GRADE A AND B RECOMMENDATIONS	\$9,673,000	\$5,962,000	\$3,711,000
28	ACA DELAY OF REDETERMINATIONS	\$6,653,000	\$4,600,150	\$2,052,850
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$796,000	\$0	\$796,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$40,284,000	-\$40,284,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$10,530	-\$5,270	-\$5,270
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION	-\$15,687,000	-\$7,843,500	-\$7,843,500
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION	-\$43,634,000	-\$29,904,000	-\$13,730,000
34	MANAGED CARE DRUG REBATES	-\$388,347,000	-\$194,173,500	-\$194,173,500
206	ACA EXPRESS LANE ENROLLMENT	\$71,535,000	\$70,330,600	\$1,204,400
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$4,504,962,180</b>	<b>\$4,572,959,390</b>	<b>-\$67,997,210</b>
<b>BENEFITS</b>				
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$206,024,000	\$206,024,000	\$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$145,537,000	\$145,537,000	\$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$51,410,000	\$49,936,000	\$1,474,000

Costs shown include application of payment lag and percent reflected in base calculation.

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b><u>BENEFITS</u></b>				
38	RESTORATION OF SELECT ADULT DENTAL BENEFIT	\$10,888,000	\$7,572,500	\$3,315,500
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$20,232,000
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILC	\$39,990,000	\$19,995,000	\$19,995,000
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,085,000	\$4,309,000	\$776,000
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCF	\$4,631,000	\$2,315,500	\$2,315,500
43	CCT FUND TRANSFER TO CDSS AND CDDS	\$2,678,000	\$2,678,000	\$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$540,000	\$270,000	\$270,000
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$183,000	\$183,000	\$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$131,000	\$131,000	\$0
47	INCREASED FEDERAL MATCHING FUNDS FOR FPAC	\$0	\$1,271,780	-\$1,271,780
48	HEARING AID CAP	\$0	\$0	\$0
49	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$92,051,700	-\$92,051,700
51	WOMEN'S HEALTH SERVICES	-\$8,289,990	-\$4,891,170	-\$3,398,820
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$13,558,000	-\$6,779,000	-\$6,779,000
	<b>BENEFITS SUBTOTAL</b>	<b>\$485,713,010</b>	<b>\$540,836,310</b>	<b>-\$55,123,300</b>
<b><u>PHARMACY</u></b>				
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	\$3,356,000	\$1,678,000	\$1,678,000
54	NON FFP DRUGS	\$0	-\$1,920,000	\$1,920,000
55	BCCTP DRUG REBATES	-\$15,389,000	-\$10,002,850	-\$5,386,150
56	MEDICAL SUPPLY REBATES	-\$18,321,000	-\$9,160,500	-\$9,160,500
57	FAMILY PACT DRUG REBATES	-\$72,232,000	-\$62,983,600	-\$9,248,400
58	LITIGATION SETTLEMENTS	-\$81,772,000	\$0	-\$81,772,000
59	AGED AND DISPUTED DRUG REBATES	-\$150,000,000	-\$75,388,800	-\$74,611,200
60	STATE SUPPLEMENTAL DRUG REBATES	-\$165,789,000	-\$83,324,100	-\$82,464,900
61	FEDERAL DRUG REBATE PROGRAM	-\$1,335,187,000	-\$727,054,300	-\$608,132,700
	<b>PHARMACY SUBTOTAL</b>	<b>-\$1,835,334,000</b>	<b>-\$968,156,150</b>	<b>-\$867,177,850</b>
<b><u>DRUG MEDI-CAL</u></b>				
66	VOLUNTARY INPATIENT DETOXIFICATION	\$9,468,000	\$5,438,000	\$4,030,000
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$3,036,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$12,504,000</b>	<b>\$8,474,000</b>	<b>\$4,030,000</b>
<b><u>MENTAL HEALTH</u></b>				
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	\$293,819,000	\$293,819,000	\$0
72	ELIMINATION OF STATE MAXIMUM RATES	\$124,190,000	\$124,190,000	\$0
73	TRANSITION OF HFP - SMH SERVICES	\$32,619,000	\$32,619,000	\$0
74	KATIE A. V. DIANA BONTA	\$27,955,000	\$27,955,000	\$0
75	HEALTHY FAMILIES - SED	\$18,731,000	\$18,731,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$12,400,000	\$12,400,000	\$0
77	OVER ONE-YEAR CLAIMS	\$3,000,000	\$3,000,000	\$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	\$2,270,000	\$2,270,000	\$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPA	\$0	-\$7,204,000	\$7,204,000

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## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>MENTAL HEALTH</b>				
80	IMD ANCILLARY SERVICES	\$0	-\$6,000,000	\$6,000,000
81	CHART REVIEW	-\$1,475,000	-\$1,475,000	\$0
82	REIMBURSEMENT IN IMD ANCILLARY SERVICES CO	-\$12,000,000	\$0	-\$12,000,000
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-\$41,760,000	-\$69,537,000	\$27,777,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$459,749,000</b>	<b>\$430,768,000</b>	<b>\$28,981,000</b>
<b>WAIVER--MH/UCD &amp; BTR</b>				
84	BTR - LIHP - MCE	\$5,495,397,000	\$3,156,611,500	\$2,338,785,500
85	MH/UCD & BTR—DSH PAYMENT	\$1,599,070,000	\$1,254,543,000	\$344,527,000
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	\$1,485,648,000	\$742,824,000	\$742,824,000
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEM	\$603,508,000	\$301,754,000	\$301,754,000
88	BTR—SAFETY NET CARE POOL	\$317,250,000	\$317,250,000	\$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	\$248,602,000	\$124,301,000	\$124,301,000
90	BTR—LOW INCOME HEALTH PROGRAM - HCCI	\$180,186,000	\$135,282,000	\$44,904,000
91	MH/UCD & BTR—CCS AND GHPP	\$129,858,000	\$129,858,000	\$0
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	\$110,000,000	\$55,000,000	\$55,000,000
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SV	\$100,000,000	\$50,000,000	\$50,000,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COS	\$82,000,000	\$82,000,000	\$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	\$66,339,000	\$397,536,000	-\$331,197,000
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INI	\$56,473,000	\$56,473,000	\$0
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$44,531,900	\$22,265,950	\$22,265,950
98	BTR—INCREASE SAFETY NET CARE POOL	\$30,750,000	\$30,750,000	\$0
99	MH/UCD—STABILIZATION FUNDING	\$13,988,000	\$0	\$13,988,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	\$11,877,000	\$11,877,000	\$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HI	\$10,193,000	\$10,193,000	\$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$9,613,000	\$9,613,000	\$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$8,510,000	\$4,255,000	\$4,255,000
104	MH/UCD—SAFETY NET CARE POOL	\$1,949,000	\$1,949,000	\$0
105	MH/UCD & BTR—MIA-LTC	\$0	\$19,327,000	-\$19,327,000
106	MH/UCD & BTR—BCCTP	\$0	\$1,786,000	-\$1,786,000
107	MH/UCD & BTR—DPH INTERIM RATE	\$0	\$441,435,000	-\$441,435,000
108	BTR—INCREASE DESIGNATED STATE HEALTH PROC	\$0	\$30,750,000	-\$30,750,000
109	HOSPITAL STABILIZATION	\$0	\$0	\$0
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	\$20,762,000	-\$20,762,000
111	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS	\$0	\$0	\$0
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOV	-\$61,500,000	-\$61,500,000	\$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLO	-\$71,229,360	-\$35,614,680	-\$35,614,680
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$10,473,013,540</b>	<b>\$7,311,280,770</b>	<b>\$3,161,732,770</b>
<b>MANAGED CARE</b>				
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$783,819,000	\$438,225,000	\$345,594,000
118	MANAGED CARE RATE RANGE IGTS	\$744,394,000	\$389,094,000	\$355,300,000

Costs shown include application of payment lag and percent reflected in base calculation.

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>				
119	TRANSITION OF DUAL ELIGIBLES-MANAGED CARE P	\$125,278,000	\$64,004,500	\$61,273,500
120	MANAGED CARE PUBLIC HOSPITAL IGTS	\$443,548,000	\$221,774,000	\$221,774,000
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION	\$383,441,000	\$191,720,500	\$191,720,500
123	TRANSFER OF IHSS COSTS TO CDSS	\$45,505,000	\$0	\$45,505,000
124	RETRO MC RATE ADJUSTMENTS	\$338,810,000	\$169,405,000	\$169,405,000
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	\$21,097,000	\$10,548,500	\$10,548,500
128	INCREASE IN CAPITATION RATES FOR GROSS PREM	\$8,862,000	\$4,504,000	\$4,358,000
131	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$0	\$2,000,000
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX T	\$0	\$0	\$0
134	EXTEND GROSS PREMIUM TAX	\$0	\$0	\$0
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0
136	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTME	\$0	\$0	\$0
138	FFS COSTS FOR MANAGED CARE ENROLLEES	\$0	\$0	\$0
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMEI	\$0	\$0	\$0
140	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0
142	DISCONTINUE UNDOCUMENTED BENEFICIARIES FR	-\$1,100,000	-\$550,000	-\$550,000
143	TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE	-\$140,711,000	-\$70,355,500	-\$70,355,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$2,754,943,000</b>	<b>\$1,418,370,000</b>	<b>\$1,336,573,000</b>
<b>PROVIDER RATES</b>				
24	AB 1629 ADD-ONS	\$19,207,540	\$9,603,770	\$9,603,770
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$191,722,540	\$95,861,270	\$95,861,270
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$68,001,180	\$34,000,590	\$34,000,590
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	\$40,673,000	\$20,336,500	\$20,336,500
147	AIR AMBULANCE MEDICAL TRANSPORTATION	\$18,459,860	\$9,229,930	\$9,229,930
148	LTC RATE ADJUSTMENT	\$17,484,220	\$8,742,110	\$8,742,110
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$5,507,400	\$2,753,700	\$2,753,700
150	HOSPICE RATE INCREASES	\$4,291,080	\$2,145,540	\$2,145,540
151	LONG TERM CARE QUALITY ASSURANCE FUND EXP	\$0	\$0	\$0
152	NON-AB 1629 LTC RATE FREEZE	-\$1,872,000	-\$936,000	-\$936,000
153	DENTAL RETROACTIVE RATE CHANGES	-\$4,782,000	-\$2,391,000	-\$2,391,000
154	LABORATORY RATE METHODOLOGY CHANGE	-\$8,477,900	-\$4,238,950	-\$4,238,950
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$12,658,290	-\$6,329,150	-\$6,329,140
156	REDUCTION TO RADIOLOGY RATES	-\$28,638,160	-\$14,319,080	-\$14,319,080
157	10% PROVIDER PAYMENT REDUCTION	-\$234,007,470	-\$117,003,730	-\$117,003,730
	<b>PROVIDER RATES SUBTOTAL</b>	<b>\$74,910,990</b>	<b>\$37,455,500</b>	<b>\$37,455,500</b>
<b>SUPPLEMENTAL PMNTS.</b>				
158	HOSPITAL QAF - HOSPITAL PAYMENTS	\$4,209,680,000	\$2,094,725,000	\$2,114,955,000
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$2,261,177,000	\$1,123,839,000	\$1,137,338,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	\$455,989,000	\$455,989,000	\$0

Costs shown include application of payment lag and percent reflected in base calculation.

## SUMMARY OF REGULAR POLICY CHANGES FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>SUPPLEMENTAL PMNTS.</b>				
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$190,500,000	\$190,500,000	\$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT	\$179,174,000	\$179,174,000	\$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	\$140,000,000	\$70,000,000	\$70,000,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	\$117,889,000	\$117,889,000	\$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	\$117,187,000	\$68,497,500	\$48,689,500
166	FFP FOR LOCAL TRAUMA CENTERS	\$100,000,000	\$50,000,000	\$50,000,000
167	IGT PAYMENTS FOR HOSPITAL SERVICES	\$15,000,000	\$7,500,000	\$7,500,000
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSI	\$10,000,000	\$5,000,000	\$5,000,000
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRI	\$8,000,000	\$4,000,000	\$4,000,000
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEN	\$5,475,000	\$5,475,000	\$0
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$7,810,071,000</b>	<b>\$4,372,588,500</b>	<b>\$3,437,482,500</b>
<b>OTHER</b>				
177	ARRA HITECH - PROVIDER PAYMENTS	\$240,434,000	\$240,434,000	\$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- C	\$133,245,000	\$133,245,000	\$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	\$11,487,000	\$5,743,500	\$5,743,500
184	CDDS DENTAL SERVICES	\$11,430,000	\$0	\$11,430,000
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDC	\$20,565,000	\$11,825,000	\$8,740,000
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	\$7,837,000	\$5,486,000	\$2,351,000
187	AUDIT SETTLEMENTS	\$8,247,000	\$0	\$8,247,000
191	INDIAN HEALTH SERVICES	\$1,254,000	\$10,689,500	-\$9,435,500
192	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0
193	ANTI-FRAUD ACTIVITIES	\$0	\$0	\$0
194	CLPP FUND	\$0	\$0	\$0
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0
196	AB 97 INJUNCTIONS	\$0	\$0	\$0
197	TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0
200	MEDICARE BUY-IN QUALITY REVIEW PROJECT	-\$720,000	-\$36,000	-\$684,000
201	IHSS REDUCTION IN SERVICE HOURS	-\$196,331,000	-\$196,331,000	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$237,448,000</b>	<b>\$211,056,000</b>	<b>\$26,392,000</b>
	<b>GRAND TOTAL</b>	<b>\$27,024,558,580</b>	<b>\$19,320,673,290</b>	<b>\$7,703,885,280</b>

Costs shown include application of payment lag and percent reflected in base calculation.

## MEDI-CAL EXPENDITURES BY SERVICE CATEGORY FISCAL YEAR 2013-14

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>PROFESSIONAL</b>	\$6,315,862,270	\$3,995,493,930	\$2,320,368,340
PHYSICIANS	\$1,405,588,020	\$984,831,080	\$420,756,930
OTHER MEDICAL	\$3,441,882,160	\$2,180,709,760	\$1,261,172,410
COUNTY OUTPATIENT	\$142,407,890	\$111,381,890	\$31,026,000
COMMUNITY OUTPATIENT	\$1,325,984,200	\$718,571,200	\$607,412,990
<b>PHARMACY</b>	\$995,111,040	\$511,626,180	\$483,484,860
<b>HOSPITAL INPATIENT</b>	\$10,263,884,270	\$6,364,677,950	\$3,899,206,330
COUNTY INPATIENT	\$2,094,292,860	\$1,814,937,630	\$279,355,230
COMMUNITY INPATIENT	\$8,169,591,420	\$4,549,740,320	\$3,619,851,100
<b>LONG TERM CARE</b>	\$4,977,079,390	\$2,573,740,030	\$2,403,339,360
NURSING FACILITIES	\$4,592,061,550	\$2,377,218,150	\$2,214,843,400
ICF-DD	\$385,017,840	\$196,521,880	\$188,495,960
<b>OTHER SERVICES</b>	\$1,191,783,270	\$698,769,140	\$493,014,130
MEDICAL TRANSPORTATION	\$353,294,870	\$272,126,580	\$81,168,290
OTHER SERVICES	\$589,510,840	\$299,846,520	\$289,664,320
HOME HEALTH	\$248,977,570	\$126,796,040	\$122,181,530
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$23,743,720,250</b>	<b>\$14,144,307,230</b>	<b>\$9,599,413,020</b>
<b>MANAGED CARE</b>	\$23,231,037,950	\$13,598,805,250	\$9,632,232,700
TWO PLAN MODEL	\$13,902,387,070	\$8,250,103,190	\$5,652,283,880
COUNTY ORGANIZED HEALTH SYSTEMS	\$6,443,040,490	\$3,700,011,810	\$2,743,028,680
GEOGRAPHIC MANAGED CARE	\$2,321,861,310	\$1,366,300,060	\$955,561,250
PHP & OTHER MANAG. CARE	\$563,749,090	\$282,390,200	\$281,358,890
<b>DENTAL</b>	\$632,838,310	\$345,548,730	\$287,289,580
<b>MENTAL HEALTH</b>	\$1,796,083,700	\$1,759,832,000	\$36,251,710
<b>AUDITS/ LAWSUITS</b>	-\$69,007,390	\$1,262,050	-\$70,269,440
<b>EPSDT SCREENS</b>	\$37,239,130	\$19,052,060	\$18,187,070
<b>MEDICARE PAYMENTS</b>	\$4,037,588,000	\$1,199,332,500	\$2,838,255,500
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$262,208,690	\$262,196,520	\$12,170
<b>MISC. SERVICES</b>	\$12,232,288,220	\$9,359,785,200	\$2,872,503,010
<b>RECOVERIES</b>	-\$262,990,000	-\$130,295,000	-\$132,695,000
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$65,641,006,870</b>	<b>\$40,559,826,540</b>	<b>\$25,081,180,330</b>

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY  
NOVEMBER 2013 ESTIMATE COMPARED TO APPROPRIATION  
FISCAL YEAR 2013-14**

<u>SERVICE CATEGORY</u>	<u>2013-14 APPROPRIATION</u>	<u>NOV. 2013 EST. FOR 2013-14</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
<b>PROFESSIONAL</b>	\$6,211,252,790	\$6,315,862,270	\$104,609,470	1.68
PHYSICIANS	\$1,503,439,280	\$1,405,588,020	-\$97,851,260	-6.51
OTHER MEDICAL	\$3,128,204,740	\$3,441,882,160	\$313,677,420	10.03
COUNTY OUTPATIENT	\$56,860,330	\$142,407,890	\$85,547,570	150.45
COMMUNITY OUTPATIENT	\$1,522,748,450	\$1,325,984,200	-\$196,764,250	-12.92
<b>PHARMACY</b>	\$339,789,840	\$995,111,040	\$655,321,200	192.86
<b>HOSPITAL INPATIENT</b>	\$11,421,243,700	\$10,263,884,270	-\$1,157,359,430	-10.13
COUNTY INPATIENT	\$2,769,079,950	\$2,094,292,860	-\$674,787,100	-24.37
COMMUNITY INPATIENT	\$8,652,163,750	\$8,169,591,420	-\$482,572,330	-5.58
<b>LONG TERM CARE</b>	\$4,658,999,010	\$4,977,079,390	\$318,080,380	6.83
NURSING FACILITIES	\$4,314,190,850	\$4,592,061,550	\$277,870,700	6.44
ICF-DD	\$344,808,160	\$385,017,840	\$40,209,680	11.66
<b>OTHER SERVICES</b>	\$1,099,974,840	\$1,191,783,270	\$91,808,430	8.35
MEDICAL TRANSPORTATION	\$308,273,930	\$353,294,870	\$45,020,940	14.60
OTHER SERVICES	\$572,236,050	\$589,510,840	\$17,274,790	3.02
HOME HEALTH	\$219,464,870	\$248,977,570	\$29,512,700	13.45
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$23,731,260,190</b>	<b>\$23,743,720,250</b>	<b>\$12,460,060</b>	<b>0.05</b>
<b>MANAGED CARE</b>	\$22,048,885,100	\$23,231,037,950	\$1,182,152,860	5.36
TWO PLAN MODEL	\$13,672,939,190	\$13,902,387,070	\$229,447,880	1.68
COUNTY ORGANIZED HEALTH SYSTEMS	\$5,861,662,600	\$6,443,040,490	\$581,377,890	9.92
GEOGRAPHIC MANAGED CARE	\$2,169,581,330	\$2,321,861,310	\$152,279,990	7.02
PHP & OTHER MANAG. CARE	\$344,701,980	\$563,749,090	\$219,047,100	63.55
<b>DENTAL</b>	\$622,285,160	\$632,838,310	\$10,553,160	1.70
<b>MENTAL HEALTH</b>	\$2,988,603,500	\$1,796,083,700	-\$1,192,519,790	-39.90
<b>AUDITS/ LAWSUITS</b>	\$10,174,220	-\$69,007,390	-\$79,181,600	-778.26
<b>EPSDT SCREENS</b>	\$39,457,540	\$37,239,130	-\$2,218,410	-5.62
<b>MEDICARE PAYMENTS</b>	\$4,044,466,000	\$4,037,588,000	-\$6,878,000	-0.17
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$242,082,830	\$262,208,690	\$20,125,860	8.31
<b>MISC. SERVICES</b>	\$11,723,140,260	\$12,232,288,220	\$509,147,960	4.34
<b>RECOVERIES</b>	-\$253,476,400	-\$262,990,000	-\$9,513,600	3.75
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$65,196,878,390</b>	<b>\$65,641,006,870</b>	<b>\$444,128,480</b>	<b>0.68</b>
<b>STATE FUNDS</b>	<b>\$25,823,189,190</b>	<b>\$25,081,180,330</b>	<b>-\$742,008,860</b>	<b>-2.87</b>

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>							
1	TRANSITION OF HFP TO MEDI-CAL	\$1,103,252,000	\$386,138,200	\$1,195,670,000	\$418,484,500	\$92,418,000	\$32,346,300
2	FAMILY PACT PROGRAM	\$645,619,000	\$161,547,900	\$632,717,000	\$158,474,900	-\$12,902,000	-\$3,073,000
3	BREAST AND CERVICAL CANCER TREATMENT	\$142,761,000	\$62,727,800	\$154,126,000	\$67,664,450	\$11,365,000	\$4,936,650
4	AIM LINKED INFANTS 250-300% FPL	\$33,357,000	\$11,674,950	\$33,357,000	\$11,674,950	\$0	\$0
5	MEDI-CAL ADULT INMATE PROGRAMS	\$21,669,000	\$0	\$12,557,000	\$0	-\$9,112,000	\$0
6	CHDP GATEWAY - PREENROLLMENT	\$15,022,000	\$5,257,700	\$11,937,000	\$4,177,950	-\$3,085,000	-\$1,079,750
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	\$6,932,000	\$0	\$6,467,000	\$0	-\$465,000	\$0
8	REFUGEES	\$5,199,000	\$5,199,000	\$5,887,000	\$5,887,000	\$688,000	\$688,000
9	MCHA VS. DHCS AND MRMIB	\$540,000	\$270,000	\$540,000	\$270,000	\$0	\$0
11	NEW QUALIFIED IMMIGRANTS	\$0	\$68,153,000	\$0	\$63,554,000	\$0	-\$4,599,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	-\$54,200,850	\$0	-\$56,409,300	\$0	-\$2,208,450
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	-\$9,072,100	\$0	-\$8,901,500	\$0	\$170,600
14	INCARCERATION VERIFICATION PROGRAM	-\$168,000	-\$84,000	-\$211,000	-\$105,500	-\$43,000	-\$21,500
15	PARIS-FEDERAL	-\$6,634,000	-\$3,317,000	-\$7,682,000	-\$3,841,000	-\$1,048,000	-\$524,000
16	PARIS-VETERANS	-\$1,678,250	-\$839,130	-\$3,542,510	-\$1,771,260	-\$1,864,260	-\$932,130
17	PARIS-INTERSTATE	-\$22,339,000	-\$11,169,500	-\$26,010,000	-\$13,005,000	-\$3,671,000	-\$1,835,500
--	250% WORKING DISABLED PROGRAM CHANGES	\$2,320,000	\$1,560,000	\$0	\$0	-\$2,320,000	-\$1,560,000
--	LOMELI V. SHEWRY	\$504,000	\$252,000	\$0	\$0	-\$504,000	-\$252,000
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$1,946,355,750</b>	<b>\$624,097,970</b>	<b>\$2,015,812,490</b>	<b>\$646,154,190</b>	<b>\$69,456,740</b>	<b>\$22,056,220</b>
<b>AFFORDABLE CARE ACT</b>							
18	ACA OPTIONAL EXPANSION	\$1,426,631,000	\$0	\$2,609,318,000	\$0	\$1,182,687,000	\$0
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$1,357,030,130	\$123,183,190	\$1,661,805,710	\$33,670,960	\$304,775,580	-\$89,512,240
20	COMMUNITY FIRST CHOICE OPTION	\$322,584,000	\$0	\$238,923,000	\$0	-\$83,661,000	\$0
21	ACA MANDATORY EXPANSION	\$228,164,000	\$107,800,000	\$222,825,000	\$103,754,350	-\$5,339,000	-\$4,045,650

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>AFFORDABLE CARE ACT</u></b>							
22	MENTAL HEALTH SERVICES EXPANSION	\$79,315,000	\$31,910,000	\$73,695,000	\$28,427,000	-\$5,620,000	-\$3,483,000
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	\$24,631,000	\$0	\$24,252,000	\$0	-\$379,000	\$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$0	\$0	\$18,672,000	\$9,168,500	\$18,672,000	\$9,168,500
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	-\$7,205,000	-\$2,654,000	\$14,493,000	\$5,254,000	\$21,698,000	\$7,908,000
27	USPSTF GRADE A AND B RECOMMENDATIONS	\$0	\$0	\$9,673,000	\$3,711,000	\$9,673,000	\$3,711,000
28	ACA DELAY OF REDETERMINATIONS	\$0	\$0	\$6,653,000	\$2,052,850	\$6,653,000	\$2,052,850
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$803,000	\$803,000	\$796,000	\$796,000	-\$7,000	-\$7,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	-\$7,500,000	\$0	-\$40,284,000	\$0	-\$32,784,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$43,510	-\$21,750	-\$10,530	-\$5,270	\$32,980	\$16,490
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION	-\$24,013,000	-\$12,006,500	-\$15,687,000	-\$7,843,500	\$8,326,000	\$4,163,000
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION	-\$70,421,000	-\$24,691,500	-\$43,634,000	-\$13,730,000	\$26,787,000	\$10,961,500
34	MANAGED CARE DRUG REBATES	-\$348,403,000	-\$174,201,500	-\$388,347,000	-\$194,173,500	-\$39,944,000	-\$19,972,000
206	ACA EXPRESS LANE ENROLLMENT	\$0	\$0	\$71,535,000	\$1,204,400	\$71,535,000	\$1,204,400
--	ACA EXPANSION-LTSS FOR OPTIONAL EXPANSION	\$251,173,000	\$0	\$0	\$0	-\$251,173,000	\$0
--	ACA EXPANSION-PREGNANCY ONLY	-\$52,047,000	-\$26,023,500	\$0	\$0	\$52,047,000	\$26,023,500
--	ENHANCE DRUG MEDI-CAL SVCS	\$80,025,000	\$34,771,000	\$0	\$0	-\$80,025,000	-\$34,771,000
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$3,268,223,620</b>	<b>\$51,368,440</b>	<b>\$4,504,962,180</b>	<b>-\$67,997,210</b>	<b>\$1,236,738,560</b>	<b>-\$119,365,650</b>
<b><u>BENEFITS</u></b>							
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$259,483,000	\$0	\$206,024,000	\$0	-\$53,459,000	\$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$142,840,000	\$0	\$145,537,000	\$0	\$2,697,000	\$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$32,651,000	\$3,968,000	\$51,410,000	\$1,474,000	\$18,759,000	-\$2,494,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFITS	\$51,057,000	\$15,520,000	\$10,888,000	\$3,315,500	-\$40,169,000	-\$12,204,500
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$40,464,000	\$20,232,000	\$0	\$0
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOT	\$27,637,000	\$13,818,500	\$39,990,000	\$19,995,000	\$12,353,000	\$6,176,500

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>BENEFITS</u></b>							
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,688,000	-\$711,000	\$5,085,000	\$776,000	-\$603,000	\$1,487,000
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREI	\$4,506,000	\$2,253,000	\$4,631,000	\$2,315,500	\$125,000	\$62,500
43	CCT FUND TRANSFER TO CDSS AND CDDS	\$4,227,000	\$0	\$2,678,000	\$0	-\$1,549,000	\$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$540,000	\$270,000	\$540,000	\$270,000	\$0	\$0
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$337,000	\$0	\$183,000	\$0	-\$154,000	\$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$170,000	\$0	\$131,000	\$0	-\$39,000	\$0
47	INCREASED FEDERAL MATCHING FUNDS FOR FPACT	\$0	-\$3,794,100	\$0	-\$3,794,100	\$0	\$0
48	HEARING AID CAP	-\$1,434,000	-\$717,000	-\$1,434,000	-\$717,000	\$0	\$0
49	SCHIP FUNDING FOR PRENATAL CARE	\$0	-\$89,878,100	\$0	-\$92,051,700	\$0	-\$2,173,600
51	WOMEN'S HEALTH SERVICES	\$0	\$0	-\$8,289,990	-\$3,398,820	-\$8,289,990	-\$3,398,820
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$23,880,000	-\$11,940,000	-\$13,558,000	-\$6,779,000	\$10,322,000	\$5,161,000
--	ADHC TRANSITION-BENEFITS	\$281,754,000	\$140,877,000	\$0	\$0	-\$281,754,000	-\$140,877,000
--	COPAYMENT FOR NON-EMERGENCY ER VISITS	-\$33,707,000	-\$16,853,500	\$0	\$0	\$33,707,000	\$16,853,500
--	ELIMINATION OF OTC COUGH AND COLD PRODUCTS	-\$4,432,000	-\$2,216,000	\$0	\$0	\$4,432,000	\$2,216,000
--	FAMILY PACT RETROACTIVE ELIGIBILITY	\$3,000	\$300	\$0	\$0	-\$3,000	-\$300
	<b>BENEFITS SUBTOTAL</b>	<b>\$787,904,000</b>	<b>\$70,829,100</b>	<b>\$484,279,010</b>	<b>-\$58,362,620</b>	<b>-\$303,624,990</b>	<b>-\$129,191,720</b>
<b><u>PHARMACY</u></b>							
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	\$3,356,000	\$1,678,000	\$3,356,000	\$1,678,000	\$0	\$0
54	NON FFP DRUGS	\$0	\$1,912,000	\$0	\$1,920,000	\$0	\$8,000
55	BCCTP DRUG REBATES	-\$16,000,000	-\$5,600,000	-\$15,389,000	-\$5,386,150	\$611,000	\$213,850
56	MEDICAL SUPPLY REBATES	-\$19,476,000	-\$9,738,000	-\$18,321,000	-\$9,160,500	\$1,155,000	\$577,500
57	FAMILY PACT DRUG REBATES	-\$73,946,000	-\$9,675,000	-\$72,232,000	-\$9,248,400	\$1,714,000	\$426,600
58	LITIGATION SETTLEMENTS	\$0	\$0	-\$81,772,000	-\$81,772,000	-\$81,772,000	-\$81,772,000
59	AGED AND DISPUTED DRUG REBATES	-\$135,000,000	-\$67,433,600	-\$150,000,000	-\$74,611,200	-\$15,000,000	-\$7,177,600

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>PHARMACY</b>							
60	STATE SUPPLEMENTAL DRUG REBATES	-\$152,549,000	-\$76,153,300	-\$165,789,000	-\$82,464,900	-\$13,240,000	-\$6,311,600
61	FEDERAL DRUG REBATE PROGRAM	-\$1,258,766,000	-\$572,381,400	-\$1,335,187,000	-\$608,132,700	-\$76,421,000	-\$35,751,300
--	IMPLEMENTATION OF SPECIALTY DRUG CONTRACTS	-\$13,985,390	-\$6,992,690	\$0	\$0	\$13,985,390	\$6,992,690
--	KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS	\$4,800,000	\$2,400,000	\$0	\$0	-\$4,800,000	-\$2,400,000
--	PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT	-\$15,157,000	-\$7,578,500	\$0	\$0	\$15,157,000	\$7,578,500
--	SUNSET OF SPECIALTY DRUG CONTRACTS	\$13,985,390	\$6,992,690	\$0	\$0	-\$13,985,390	-\$6,992,690
	<b>PHARMACY SUBTOTAL</b>	<b>-\$1,662,738,000</b>	<b>-\$742,569,800</b>	<b>-\$1,835,334,000</b>	<b>-\$867,177,850</b>	<b>-\$172,596,000</b>	<b>-\$124,608,050</b>
<b>DRUG MEDI-CAL</b>							
66	VOLUNTARY INPATIENT DETOXIFICATION	\$0	\$0	\$9,468,000	\$4,030,000	\$9,468,000	\$4,030,000
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	-\$1,859,000	\$0	\$3,036,000	\$0	\$4,895,000	\$0
--	ANNUAL RATE ADJUSTMENT	-\$1,627,000	\$0	\$0	\$0	\$1,627,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>-\$3,486,000</b>	<b>\$0</b>	<b>\$12,504,000</b>	<b>\$4,030,000</b>	<b>\$15,990,000</b>	<b>\$4,030,000</b>
<b>MENTAL HEALTH</b>							
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	\$293,819,000	\$0	\$293,819,000	\$0	\$0	\$0
72	ELIMINATION OF STATE MAXIMUM RATES	\$124,484,000	\$0	\$124,190,000	\$0	-\$294,000	\$0
73	TRANSITION OF HFP - SMH SERVICES	\$32,731,000	\$0	\$32,619,000	\$0	-\$112,000	\$0
74	KATIE A. V. DIANA BONTA	\$23,161,000	\$0	\$27,955,000	\$0	\$4,794,000	\$0
75	HEALTHY FAMILIES - SED	\$22,250,000	\$0	\$18,731,000	\$0	-\$3,519,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$24,800,000	\$0	\$12,400,000	\$0	-\$12,400,000	\$0
77	OVER ONE-YEAR CLAIMS	\$3,000,000	\$0	\$3,000,000	\$0	\$0	\$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	\$2,769,000	\$0	\$2,270,000	\$0	-\$499,000	\$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	\$0	\$0	\$0	\$7,204,000	\$0	\$7,204,000
80	IMD ANCILLARY SERVICES	\$0	\$6,000,000	\$0	\$6,000,000	\$0	\$0
81	CHART REVIEW	-\$580,000	\$0	-\$1,475,000	\$0	-\$895,000	\$0

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>MENTAL HEALTH</b>							
82	REIMBURSEMENT IN IMD ANCILLARY SERVICES COST:	-\$12,000,000	-\$12,000,000	-\$12,000,000	-\$12,000,000	\$0	\$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-\$70,714,000	\$39,385,000	-\$41,760,000	\$27,777,000	\$28,954,000	-\$11,608,000
--	PAROLE MENTAL HEALTH AND MEDI-CAL EXPANSION	\$7,181,000	\$0	\$0	\$0	-\$7,181,000	\$0
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$450,901,000</b>	<b>\$33,385,000</b>	<b>\$459,749,000</b>	<b>\$28,981,000</b>	<b>\$8,848,000</b>	<b>-\$4,404,000</b>
<b>WAIVER--MH/UCD &amp; BTR</b>							
84	BTR - LIHP - MCE	\$4,770,999,000	\$2,090,531,000	\$5,495,397,000	\$2,338,785,500	\$724,398,000	\$248,254,500
85	MH/UCD & BTR—DSH PAYMENT	\$1,774,361,000	\$622,248,000	\$1,599,070,000	\$344,527,000	-\$175,291,000	-\$277,721,000
86	BTR—DPH DELIVERY SYSTEM REFORM INCENTIVE PC	\$1,435,292,000	\$717,646,000	\$1,485,648,000	\$742,824,000	\$50,356,000	\$25,178,000
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEME	\$546,058,000	\$273,029,000	\$603,508,000	\$301,754,000	\$57,450,000	\$28,725,000
88	BTR—SAFETY NET CARE POOL	\$317,250,000	\$0	\$317,250,000	\$0	\$0	\$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL F	\$339,269,000	\$169,634,500	\$248,602,000	\$124,301,000	-\$90,667,000	-\$45,333,500
90	BTR—LOW INCOME HEALTH PROGRAM - HCCI	\$161,299,000	\$13,470,000	\$180,186,000	\$44,904,000	\$18,887,000	\$31,434,000
91	MH/UCD & BTR—CCS AND GHPP	\$130,627,000	\$0	\$129,858,000	\$0	-\$769,000	\$0
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	\$110,000,000	\$55,000,000	\$110,000,000	\$55,000,000	\$0	\$0
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	\$126,400,000	\$63,200,000	\$100,000,000	\$50,000,000	-\$26,400,000	-\$13,200,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	\$77,960,000	\$0	\$82,000,000	\$0	\$4,040,000	\$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	\$66,339,000	-\$279,331,000	\$66,339,000	-\$331,197,000	\$0	-\$51,866,000
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMA	\$29,503,000	\$0	\$56,473,000	\$0	\$26,970,000	\$0
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$116,992,000	\$58,496,000	\$48,791,390	\$24,395,690	-\$68,200,610	-\$34,100,310
98	BTR—INCREASE SAFETY NET CARE POOL	\$24,500,000	\$0	\$30,750,000	\$0	\$6,250,000	\$0
99	MH/UCD—STABILIZATION FUNDING	\$39,911,000	\$29,154,000	\$13,988,000	\$13,988,000	-\$25,923,000	-\$15,166,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	\$159,300,000	\$0	\$11,877,000	\$0	-\$147,423,000	\$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	\$23,142,000	\$0	\$10,193,000	\$0	-\$12,949,000	\$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$31,467,000	\$0	\$9,613,000	\$0	-\$21,854,000	\$0

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

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>							
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$8,141,000	\$4,070,500	\$8,510,000	\$4,255,000	\$369,000	\$184,500
104	MH/UCD—SAFETY NET CARE POOL	\$154,500,000	\$0	\$1,949,000	\$0	-\$152,551,000	\$0
105	MH/UCD & BTR—MIA-LTC	\$0	-\$19,518,000	\$0	-\$19,327,000	\$0	\$191,000
106	MH/UCD & BTR—BCCTP	\$0	-\$1,423,000	\$0	-\$1,786,000	\$0	-\$363,000
107	MH/UCD & BTR—DPH INTERIM RATE	\$0	-\$560,037,000	\$0	-\$441,435,000	\$0	\$118,602,000
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGR	\$0	-\$24,500,000	\$0	-\$30,750,000	\$0	-\$6,250,000
109	HOSPITAL STABILIZATION	-\$36,618,000	-\$18,309,000	\$0	\$0	\$36,618,000	\$18,309,000
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	-\$28,925,000	\$0	-\$20,762,000	\$0	\$8,163,000
111	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS	-\$46,000,000	-\$23,000,000	\$0	\$0	\$46,000,000	\$23,000,000
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER	-\$49,000,000	\$0	-\$61,500,000	\$0	-\$12,500,000	\$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-\$116,524,360	-\$58,262,180	-\$77,897,380	-\$38,948,690	\$38,626,980	\$19,313,490
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$10,195,167,640</b>	<b>\$3,083,173,820</b>	<b>\$10,470,605,010</b>	<b>\$3,160,528,510</b>	<b>\$275,437,370</b>	<b>\$77,354,690</b>
<b><u>MANAGED CARE</u></b>							
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$812,173,000	\$406,086,500	\$783,819,000	\$345,594,000	-\$28,354,000	-\$60,492,500
118	MANAGED CARE RATE RANGE IGTS	\$500,119,000	\$245,938,000	\$744,394,000	\$355,300,000	\$244,275,000	\$109,362,000
119	TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAY	\$1,665,138,000	\$817,466,000	\$125,278,000	\$61,273,500	-\$1,539,860,000	-\$756,192,500
120	MANAGED CARE PUBLIC HOSPITAL IGTS	\$678,988,000	\$339,494,000	\$443,548,000	\$221,774,000	-\$235,440,000	-\$117,720,000
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	\$332,796,000	\$166,398,000	\$383,441,000	\$191,720,500	\$50,645,000	\$25,322,500
123	TRANSFER OF IHSS COSTS TO CDSS	\$503,439,000	\$503,439,000	\$45,505,000	\$45,505,000	-\$457,934,000	-\$457,934,000
124	RETRO MC RATE ADJUSTMENTS	\$105,531,000	\$52,765,500	\$338,810,000	\$169,405,000	\$233,279,000	\$116,639,500
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	\$161,079,000	\$80,539,500	\$21,097,000	\$10,548,500	-\$139,982,000	-\$69,991,000
128	INCREASE IN CAPITATION RATES FOR GROSS PREMIL	\$5,512,000	\$2,711,000	\$8,862,000	\$4,358,000	\$3,350,000	\$1,647,000
131	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO C	\$0	\$0	\$0	\$0	\$0	\$0

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>							
134	EXTEND GROSS PREMIUM TAX	\$0	\$0	\$0	\$0	\$0	\$0
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0	\$0	\$0	\$0
136	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0	\$0	\$0	\$0
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMEN	\$0	\$0	\$0	\$0	\$0	\$0
138	FFS COSTS FOR MANAGED CARE ENROLLEES	\$0	\$0	\$0	\$0	\$0	\$0
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	\$0	\$0	\$0	\$0	\$0
140	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0	\$0	\$0	\$0
142	DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM	-\$535,000	-\$267,500	-\$1,100,000	-\$550,000	-\$565,000	-\$282,500
143	TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE	-\$1,152,958,000	-\$576,479,000	-\$140,711,000	-\$70,355,500	\$1,012,247,000	\$506,123,500
--	ALIGN MANAGED CARE BENEFIT POLICIES	\$106,752,000	\$53,376,000	\$0	\$0	-\$106,752,000	-\$53,376,000
--	MANAGED CARE COST-BASED REIMBURSEMENT CLIN	\$174,700,000	\$87,350,000	\$0	\$0	-\$174,700,000	-\$87,350,000
--	MANAGED CARE DEFAULT ASSIGNMENT	-\$4,531,000	-\$2,265,500	\$0	\$0	\$4,531,000	\$2,265,500
--	POTENTIALLY PREVENTABLE ADMISSIONS	-\$39,634,000	-\$19,817,000	\$0	\$0	\$39,634,000	\$19,817,000
--	SCAN TRANSITION TO MANAGED CARE	\$0	\$0	\$0	\$0	\$0	\$0
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$3,850,569,000</b>	<b>\$2,158,734,500</b>	<b>\$2,754,943,000</b>	<b>\$1,336,573,000</b>	<b>-\$1,095,626,000</b>	<b>-\$822,161,500</b>
<b>PROVIDER RATES</b>							
24	AB 1629 ADD-ONS	\$161,173,530	\$80,586,760	\$19,207,540	\$9,603,770	-\$141,965,980	-\$70,982,990
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$197,403,690	\$98,701,840	\$273,342,660	\$136,671,330	\$75,938,970	\$37,969,480
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$27,686,000	\$13,843,000	\$68,001,180	\$34,000,590	\$40,315,180	\$20,157,590
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYM	\$37,578,000	\$16,877,000	\$40,673,000	\$20,336,500	\$3,095,000	\$3,459,500
147	AIR AMBULANCE MEDICAL TRANSPORTATION	\$18,219,000	\$9,110,000	\$18,459,860	\$9,229,930	\$240,860	\$119,930
148	LTC RATE ADJUSTMENT	\$91,642,710	\$45,821,350	\$17,484,220	\$8,742,110	-\$74,158,490	-\$37,079,250
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$17,910,830	\$8,955,420	\$60,321,980	\$30,160,990	\$42,411,150	\$21,205,570
150	HOSPICE RATE INCREASES	\$10,437,740	\$5,218,870	\$4,416,510	\$2,208,250	-\$6,021,230	-\$3,010,620

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>PROVIDER RATES</b>							
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	\$0	\$0	\$0	\$0	\$0	\$0
152	NON-AB 1629 LTC RATE FREEZE	-\$72,468,610	-\$36,234,310	-\$1,872,000	-\$936,000	\$70,596,610	\$35,298,310
153	DENTAL RETROACTIVE RATE CHANGES	-\$2,000,000	-\$1,000,000	-\$4,782,000	-\$2,391,000	-\$2,782,000	-\$1,391,000
154	LABORATORY RATE METHODOLOGY CHANGE	-\$13,223,630	-\$6,611,810	-\$8,477,900	-\$4,238,950	\$4,745,730	\$2,372,870
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$71,347,000	-\$35,673,500	-\$13,035,000	-\$6,517,500	\$58,312,000	\$29,156,000
156	REDUCTION TO RADIOLOGY RATES	-\$58,264,940	-\$29,132,470	-\$28,638,160	-\$14,319,080	\$29,626,780	\$14,813,390
157	10% PROVIDER PAYMENT REDUCTION	-\$1,041,964,000	-\$520,982,000	-\$312,677,000	-\$156,338,500	\$729,287,000	\$364,643,500
--	ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMEN	-\$51,473,000	-\$25,736,500	\$0	\$0	\$51,473,000	\$25,736,500
	<b>PROVIDER RATES SUBTOTAL</b>	<b>-\$748,689,680</b>	<b>-\$376,256,340</b>	<b>\$132,424,880</b>	<b>\$66,212,440</b>	<b>\$881,114,560</b>	<b>\$442,468,780</b>
<b>SUPPLEMENTAL PMNTS.</b>							
158	HOSPITAL QAF - HOSPITAL PAYMENTS	\$4,212,457,000	\$2,127,154,000	\$4,209,680,000	\$2,114,955,000	-\$2,777,000	-\$12,199,000
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$2,438,060,000	\$1,223,680,000	\$2,261,177,000	\$1,137,338,000	-\$176,883,000	-\$86,342,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	\$455,989,000	\$0	\$455,989,000	\$0	\$0	\$0
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$160,000,000	\$0	\$190,500,000	\$0	\$30,500,000	\$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT	\$205,995,000	\$0	\$179,174,000	\$0	-\$26,821,000	\$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	\$140,000,000	\$70,000,000	\$140,000,000	\$70,000,000	\$0	\$0
164	CERTIFICATION PAYMENTS FOR DP-NFS	\$44,145,000	\$0	\$117,889,000	\$0	\$73,744,000	\$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	\$112,557,000	\$46,043,000	\$117,187,000	\$48,689,500	\$4,630,000	\$2,646,500
166	FFP FOR LOCAL TRAUMA CENTERS	\$82,000,000	\$41,000,000	\$100,000,000	\$50,000,000	\$18,000,000	\$9,000,000
167	IGT PAYMENTS FOR HOSPITAL SERVICES	\$15,000,000	\$7,500,000	\$15,000,000	\$7,500,000	\$0	\$0
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,000,000	\$5,000,000	\$0	\$0
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$4,000,000	\$0	\$0
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENT:	\$3,600,000	\$0	\$5,475,000	\$0	\$1,875,000	\$0
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$7,887,803,000</b>	<b>\$3,524,377,000</b>	<b>\$7,810,071,000</b>	<b>\$3,437,482,500</b>	<b>-\$77,732,000</b>	<b>-\$86,894,500</b>

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

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER</b>							
177	ARRA HITECH - PROVIDER PAYMENTS	\$395,625,000	\$0	\$240,434,000	\$0	-\$155,191,000	\$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CD	\$198,021,000	\$0	\$133,245,000	\$0	-\$64,776,000	\$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	\$2,177,000	\$1,088,500	\$11,487,000	\$5,743,500	\$9,310,000	\$4,655,000
184	CDDS DENTAL SERVICES	\$11,430,000	\$11,430,000	\$11,430,000	\$11,430,000	\$0	\$0
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$11,418,000	\$5,709,000	\$20,565,000	\$8,740,000	\$9,147,000	\$3,031,000
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	\$0	\$0	\$7,837,000	\$2,351,000	\$7,837,000	\$2,351,000
187	AUDIT SETTLEMENTS	\$6,298,000	\$6,298,000	\$8,247,000	\$8,247,000	\$1,949,000	\$1,949,000
191	INDIAN HEALTH SERVICES	\$2,524,000	-\$9,273,500	\$1,254,000	-\$9,435,500	-\$1,270,000	-\$162,000
192	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0	\$0	\$0	\$0
193	ANTI-FRAUD ACTIVITIES	-\$13,800,000	-\$6,900,000	-\$15,000,000	-\$7,500,000	-\$1,200,000	-\$600,000
194	CLPP FUND	\$0	\$0	\$0	\$0	\$0	\$0
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0	\$0	\$0	\$0
196	AB 97 INJUNCTIONS	\$195,701,000	\$97,850,500	\$0	\$0	-\$195,701,000	-\$97,850,500
197	TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0	\$0	\$0	\$0
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0	\$0	\$0	\$0
200	MEDICARE BUY-IN QUALITY REVIEW PROJECT	-\$4,000,000	-\$3,800,000	-\$4,000,000	-\$3,800,000	\$0	\$0
201	IHSS REDUCTION IN SERVICE HOURS	-\$154,157,000	\$0	-\$196,331,000	\$0	-\$42,174,000	\$0
--	FQHC/RHC AUDIT STAFFING	-\$12,723,000	-\$6,361,500	\$0	\$0	\$12,723,000	\$6,361,500
--	OPERATIONAL FLEXIBILITIES	\$0	\$0	\$0	\$0	\$0	\$0
--	OVERPAYMENTS - INTEREST RATE CHANGE	-\$3,112,000	-\$3,112,000	\$0	\$0	\$3,112,000	\$3,112,000
--	TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVING:	\$0	\$0	\$0	\$0	\$0	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$635,402,000</b>	<b>\$92,929,000</b>	<b>\$219,168,000</b>	<b>\$15,776,000</b>	<b>-\$416,234,000</b>	<b>-\$77,153,000</b>
	<b>GRAND TOTAL</b>	<b>\$26,607,412,330</b>	<b>\$8,520,068,690</b>	<b>\$27,029,184,570</b>	<b>\$7,702,199,960</b>	<b>\$421,772,240</b>	<b>-\$817,868,730</b>

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

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>PA-OAS</b>	<b>PA-AB</b>	<b>PA-ATD</b>	<b>PA-AFDC</b>	<b>LT-OAS</b>	<b>LT-AB</b>
PHYSICIANS	\$42,546,400	\$4,582,760	\$203,260,790	\$76,663,370	\$6,298,660	\$123,640
OTHER MEDICAL	\$83,280,450	\$10,294,570	\$396,061,830	\$316,831,140	\$9,893,040	\$361,780
COUNTY OUTPATIENT	\$572,510	\$139,730	\$9,394,720	\$1,757,020	\$253,400	\$20
COMMUNITY OUTPATIENT	\$10,434,370	\$1,797,100	\$135,301,390	\$30,715,820	\$737,500	\$18,320
PHARMACY	\$14,176,000	\$7,032,760	\$445,715,900	\$49,815,060	\$4,945,030	\$82,110
COUNTY INPATIENT	\$7,260,950	\$799,510	\$62,449,640	\$20,078,500	\$2,502,980	\$2,590
COMMUNITY INPATIENT	\$139,694,510	\$13,726,820	\$807,685,520	\$253,750,110	\$25,208,420	\$1,194,150
NURSING FACILITIES	\$515,801,850	\$21,826,320	\$779,506,990	\$2,346,010	\$2,002,965,390	\$7,986,090
ICF-DD	\$638,890	\$8,353,250	\$173,481,960	\$405,550	\$27,038,120	\$2,856,380
MEDICAL TRANSPORTATION	\$19,739,500	\$3,989,010	\$53,719,340	\$5,175,650	\$6,017,790	\$111,780
OTHER SERVICES	\$61,518,770	\$6,687,470	\$154,245,860	\$38,679,800	\$80,931,010	\$252,620
HOME HEALTH	\$380,290	\$12,248,530	\$132,816,780	\$3,824,420	\$23,320	\$0
<b>FFS SUBTOTAL</b>	<b>\$896,044,500</b>	<b>\$91,477,820</b>	<b>\$3,353,640,710</b>	<b>\$800,042,460</b>	<b>\$2,166,814,670</b>	<b>\$12,989,480</b>
DENTAL	\$25,854,440	\$1,318,460	\$61,645,740	\$85,862,890	\$2,778,160	\$13,530
TWO PLAN MODEL	\$322,053,430	\$57,607,260	\$3,499,071,080	\$1,636,084,740	-\$195,050	-\$195,050
COUNTY ORGANIZED HEALTH SYSTEMS	\$299,046,000	\$24,750,080	\$1,173,672,870	\$374,257,910	\$690,728,000	\$2,505,310
GEOGRAPHIC MANAGED CARE	\$56,573,480	\$10,952,610	\$671,499,760	\$278,101,070	-\$33,630	-\$33,630
PHP & OTHER MANAG. CARE	\$175,736,780	\$4,103,830	\$99,191,690	\$16,660,300	\$8,417,890	\$7,060
EPSDT SCREENS	\$0	\$0	\$0	\$9,436,850	\$0	\$0
MEDICARE PAYMENTS	\$1,376,612,350	\$41,903,130	\$1,299,954,740	\$0	\$154,676,370	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$90,870	\$1,473,190	\$56,166,800	\$543,590	\$13,348,560	\$1,013,720
MISC. SERVICES	\$614,241,860	\$32,568,900	\$3,056,799,230	\$891,960	\$1,425,540	\$0
<b>NON-FFS SUBTOTAL</b>	<b>\$2,870,209,200</b>	<b>\$174,677,470</b>	<b>\$9,918,001,900</b>	<b>\$2,401,839,300</b>	<b>\$871,145,830</b>	<b>\$3,310,930</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$3,766,253,710</b>	<b>\$266,155,290</b>	<b>\$13,271,642,610</b>	<b>\$3,201,881,760</b>	<b>\$3,037,960,500</b>	<b>\$16,300,410</b>
<b>ELIGIBLES ***</b>	<b>419,500</b>	<b>21,800</b>	<b>1,019,400</b>	<b>1,416,400</b>	<b>46,200</b>	<b>200</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$8,978</b>	<b>\$12,209</b>	<b>\$13,019</b>	<b>\$2,261</b>	<b>\$65,757</b>	<b>\$81,502</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$748</b>	<b>\$1,017</b>	<b>\$1,085</b>	<b>\$188</b>	<b>\$5,480</b>	<b>\$6,792</b>

(1) Does not include Audits &amp; Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

**Excluded policy changes: 73. Refer to page following report for listing.**

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>LT-ATD</b>	<b>MN-OAS</b>	<b>MN-AB</b>	<b>MN-ATD</b>	<b>MN-AFDC</b>	<b>MI-C</b>
PHYSICIANS	\$9,982,920	\$32,960,340	\$389,590	\$72,574,420	\$362,316,290	\$56,667,940
OTHER MEDICAL	\$8,009,910	\$83,801,810	\$916,470	\$113,474,130	\$852,304,410	\$183,089,350
COUNTY OUTPATIENT	\$574,120	\$1,993,380	\$28,480	\$9,405,700	\$20,268,500	\$2,630,020
COMMUNITY OUTPATIENT	\$1,315,300	\$8,058,130	\$140,360	\$28,574,200	\$125,433,160	\$23,310,630
PHARMACY	\$8,309,510	\$10,314,160	\$117,010	\$44,862,620	\$90,240,240	\$78,686,790
COUNTY INPATIENT	\$17,388,570	\$19,068,070	\$469,800	\$149,880,470	\$177,188,990	\$22,271,380
COMMUNITY INPATIENT	\$41,136,070	\$75,813,690	\$2,203,590	\$438,437,030	\$1,124,662,160	\$172,520,270
NURSING FACILITIES	\$591,965,950	\$250,559,290	\$594,970	\$84,246,040	\$18,844,400	\$9,479,420
ICF-DD	\$154,499,350	\$856,170	\$0	\$8,644,900	\$327,930	\$1,659,250
MEDICAL TRANSPORTATION	\$3,286,060	\$15,955,850	\$228,550	\$21,420,960	\$16,250,350	\$3,464,350
OTHER SERVICES	\$15,623,790	\$31,835,460	\$75,830	\$37,502,430	\$91,880,870	\$28,322,650
HOME HEALTH	\$30,560	\$532,330	\$83,590	\$58,047,090	\$11,115,930	\$19,657,900
<b>FFS SUBTOTAL</b>	<b>\$852,122,110</b>	<b>\$531,748,670</b>	<b>\$5,248,230</b>	<b>\$1,067,070,020</b>	<b>\$2,890,833,230</b>	<b>\$601,759,970</b>
DENTAL	\$890,630	\$18,857,330	\$37,430	\$11,153,750	\$221,120,710	\$73,598,350
TWO PLAN MODEL	-\$195,050	\$544,181,510	\$1,999,960	\$340,149,820	\$3,232,031,950	\$197,464,060
COUNTY ORGANIZED HEALTH SYSTEMS	\$260,632,660	\$251,452,440	\$564,250	\$289,605,570	\$1,099,346,030	\$129,119,690
GEOGRAPHIC MANAGED CARE	-\$33,630	\$62,790,770	\$71,310	\$50,266,500	\$460,062,030	\$25,078,260
PHP & OTHER MANAG. CARE	\$341,780	\$137,343,600	\$13,966,350	\$2,310,910	\$41,986,400	\$3,020,560
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$23,760,000	\$1,592,220
MEDICARE PAYMENTS	\$38,512,510	\$700,448,280	\$0	\$356,858,420	\$68,622,200	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$184,452,800	\$29,950	\$27,060	\$229,610	\$137,410	\$449,700
MISC. SERVICES	\$1,607,100	\$451,757,030	\$884,230	\$550,216,500	\$2,170,500	\$7,467,710
<b>NON-FFS SUBTOTAL</b>	<b>\$486,208,790</b>	<b>\$2,166,860,920</b>	<b>\$17,550,570</b>	<b>\$1,600,791,080</b>	<b>\$5,149,237,220</b>	<b>\$437,790,550</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$1,338,330,910</b>	<b>\$2,698,609,590</b>	<b>\$22,798,810</b>	<b>\$2,667,861,100</b>	<b>\$8,040,070,450</b>	<b>\$1,039,550,520</b>
<b>ELIGIBLES ***</b>	<b>14,800</b>	<b>312,100</b>	<b>600</b>	<b>184,600</b>	<b>3,585,800</b>	<b>788,400</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$90,428</b>	<b>\$8,647</b>	<b>\$37,998</b>	<b>\$14,452</b>	<b>\$2,242</b>	<b>\$1,319</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$7,536</b>	<b>\$721</b>	<b>\$3,167</b>	<b>\$1,204</b>	<b>\$187</b>	<b>\$110</b>

(1) Does not include Audits &amp; Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

**Excluded policy changes: 73. Refer to page following report for listing.**

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>MI-A</b>	<b>REFUGEE</b>	<b>OBRA</b>	<b>POV 185</b>	<b>POV 133</b>	<b>POV 100</b>
PHYSICIANS	\$33,244,000	\$350,650	\$23,844,500	\$254,081,580	\$8,652,310	\$6,989,600
OTHER MEDICAL	\$106,608,750	\$2,826,570	\$37,402,360	\$228,925,230	\$67,981,960	\$30,975,220
COUNTY OUTPATIENT	\$2,438,960	\$176,630	\$4,422,230	\$3,470,030	\$277,100	\$352,050
COMMUNITY OUTPATIENT	\$7,076,290	\$122,180	\$5,399,500	\$29,043,980	\$4,762,490	\$4,760,290
PHARMACY	\$77,315,240	\$475,810	\$9,158,630	\$8,218,970	\$4,622,920	\$6,223,000
COUNTY INPATIENT	\$16,726,310	\$75,180	\$50,257,470	\$51,697,480	\$1,036,340	\$1,898,170
COMMUNITY INPATIENT	\$95,789,900	\$658,230	\$82,718,850	\$458,067,700	\$18,979,590	\$19,708,400
NURSING FACILITIES	\$36,793,390	\$14,210	\$21,176,870	\$417,590	\$614,180	\$606,740
ICF-DD	\$583,830	\$0	\$214,870	\$0	\$0	\$2,910
MEDICAL TRANSPORTATION	\$3,844,070	\$12,640	\$3,856,710	\$1,871,530	\$405,910	\$274,960
OTHER SERVICES	\$8,129,380	\$12,410	\$1,637,240	\$11,367,320	\$12,320,870	\$5,485,740
HOME HEALTH	\$56,790	\$420	\$16,660	\$2,029,350	\$2,291,350	\$1,375,790
<b>FFS SUBTOTAL</b>	<b>\$388,606,920</b>	<b>\$4,724,920</b>	<b>\$240,105,880</b>	<b>\$1,049,190,750</b>	<b>\$121,945,020</b>	<b>\$78,652,870</b>
DENTAL	\$5,810,040	\$78,000	\$157,140	\$606,330	\$91,483,200	\$20,142,220
TWO PLAN MODEL	\$1,385,704,580	-\$2,460	\$0	\$61,408,880	\$502,929,220	\$179,374,050
COUNTY ORGANIZED HEALTH SYSTEMS	\$594,451,940	\$273,730	\$1,094,770	\$30,464,700	\$234,721,740	\$75,120,080
GEOGRAPHIC MANAGED CARE	\$219,871,090	\$569,240	\$0	\$13,173,670	\$103,933,850	\$50,268,360
PHP & OTHER MANAG. CARE	\$22,540	\$0	\$0	\$1,808,500	\$1,845,260	\$2,194,720
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$1,119,060	\$1,331,000
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$16,940	\$0	\$221,190	\$82,890	\$0	\$250,510
MISC. SERVICES	\$24,345,820	\$0	\$0	\$249,910	\$160,600	\$55,330
<b>NON-FFS SUBTOTAL</b>	<b>\$2,230,222,940</b>	<b>\$918,510</b>	<b>\$1,473,090</b>	<b>\$107,794,880</b>	<b>\$936,192,920</b>	<b>\$328,736,260</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$2,618,829,860</b>	<b>\$5,643,430</b>	<b>\$241,578,970</b>	<b>\$1,156,985,630</b>	<b>\$1,058,137,940</b>	<b>\$407,389,130</b>
<b>ELIGIBLES ***</b>	<b>329,800</b>	<b>2,400</b>	<b>61,100</b>	<b>194,000</b>	<b>574,200</b>	<b>199,200</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$7,941</b>	<b>\$2,351</b>	<b>\$3,954</b>	<b>\$5,964</b>	<b>\$1,843</b>	<b>\$2,045</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$662</b>	<b>\$196</b>	<b>\$329</b>	<b>\$497</b>	<b>\$154</b>	<b>\$170</b>

(1) Does not include Audits &amp; Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

**Excluded policy changes: 73. Refer to page following report for listing.**

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>TOTAL</b>
PHYSICIANS	\$1,195,529,770
OTHER MEDICAL	\$2,533,039,000
COUNTY OUTPATIENT	\$58,154,600
COMMUNITY OUTPATIENT	\$417,001,000
PHARMACY	\$860,311,760
COUNTY INPATIENT	\$601,052,400
COMMUNITY INPATIENT	\$3,771,955,010
NURSING FACILITIES	\$4,345,745,700
ICF-DD	\$379,563,350
MEDICAL TRANSPORTATION	\$159,625,030
OTHER SERVICES	\$586,509,510
HOME HEALTH	\$244,531,100
<b>FFS SUBTOTAL</b>	<b>\$15,153,018,230</b>
DENTAL	\$621,408,310
TWO PLAN MODEL	\$11,959,472,930
COUNTY ORGANIZED HEALTH SYSTEMS	\$5,531,807,750
GEOGRAPHIC MANAGED CARE	\$2,003,111,100
PHP & OTHER MANAG. CARE	\$508,958,180
EPSDT SCREENS	\$37,239,130
MEDICARE PAYMENTS	\$4,037,588,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$258,534,770
MISC. SERVICES	\$4,744,842,220
<b>NON-FFS SUBTOTAL</b>	<b>\$29,702,962,380</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$44,855,980,610</b>
<b>ELIGIBLES ***</b>	<b>9,170,500</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$4,891</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$408</b>

(1) Does not include Audits & Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

**Excluded policy changes: 73. Refer to page following report for listing.**

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

## EXCLUDED POLICY CHANGES: 73

2	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
6	CHDP GATEWAY - PREENROLLMENT
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION
49	SCHIP FUNDING FOR PRENATAL CARE
51	WOMEN'S HEALTH SERVICES
57	FAMILY PACT DRUG REBATES
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
84	BTR - LIHP - MCE
85	MH/UCD & BTR—DSH PAYMENT
86	BTR—DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
88	BTR—SAFETY NET CARE POOL
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYME
90	BTR—LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—CCS AND GHPP
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
95	BTR—DESIGNATED STATE HEALTH PROGRAMS
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES
98	BTR—INCREASE SAFETY NET CARE POOL
99	MH/UCD—STABILIZATION FUNDING
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PF
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
104	MH/UCD—SAFETY NET CARE POOL

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

## EXCLUDED POLICY CHANGES: 73

105	MH/UCD & BTR—MIA-LTC
106	MH/UCD & BTR—BCCTP
107	MH/UCD & BTR—DPH INTERIM RATE
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
109	HOSPITAL STABILIZATION
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
111	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNI
123	TRANSFER OF IHSS COSTS TO CDSS
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF
134	EXTEND GROSS PREMIUM TAX
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE
136	GENERAL FUND REIMBURSEMENTS FROM DPHS
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITUF
153	DENTAL RETROACTIVE RATE CHANGES
158	HOSPITAL QAF - HOSPITAL PAYMENTS
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT
163	NDPH IGT SUPPLEMENTAL PAYMENTS
164	CERTIFICATION PAYMENTS FOR DP-NFS
165	CAPITAL PROJECT DEBT REIMBURSEMENT
166	FFP FOR LOCAL TRAUMA CENTERS
167	IGT PAYMENTS FOR HOSPITAL SERVICES
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
177	ARRA HITECH - PROVIDER PAYMENTS

**FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

## EXCLUDED POLICY CHANGES: 73

180	MEDI-CAL TCM PROGRAM
184	CDDS DENTAL SERVICES
187	AUDIT SETTLEMENTS
192	CIGARETTE AND TOBACCO SURTAX FUNDS
194	CLPP FUND
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE
197	TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
212	AIM LINKED MOTHERS 200-300% FPL

## MEDI-CAL PROGRAM ESTIMATE SUMMARY FISCAL YEAR 2014-15

	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b>I. BASE ESTIMATES</b>			
A. B/Y FFS BASE	\$16,282,268,490	\$8,141,134,240	\$8,141,134,240
B. B/Y BASE POLICY CHANGES	\$23,758,925,010	\$14,080,605,050	\$9,678,319,950
C. BASE ADJUSTMENTS	-\$101,269,000	-\$193,535,100	\$92,266,100
D. ADJUSTED BASE	<u>\$39,939,924,490</u>	<u>\$22,028,204,200</u>	<u>\$17,911,720,290</u>
<b>II. REGULAR POLICY CHANGES</b>			
A. ELIGIBILITY	\$2,274,614,320	\$1,523,741,060	\$750,873,260
B. AFFORDABLE CARE ACT	\$9,250,010,600	\$8,746,758,230	\$503,252,370
C. BENEFITS	\$693,574,000	\$698,940,040	-\$5,366,040
D. PHARMACY	-\$1,933,166,000	-\$1,059,487,800	-\$873,678,200
E. DRUG MEDI-CAL	\$24,092,000	\$14,400,000	\$9,692,000
F. MENTAL HEALTH	\$346,023,000	\$352,023,000	-\$6,000,000
G. WAIVER--MH/UCD & BTR	\$4,932,302,730	\$3,815,003,860	\$1,117,298,860
H. MANAGED CARE	\$6,457,206,000	\$2,597,289,300	\$3,859,916,700
I. PROVIDER RATES	-\$23,047,730	-\$11,524,760	-\$11,522,970
J. SUPPLEMENTAL PMNTS.	\$7,658,333,000	\$3,986,938,000	\$3,671,395,000
K. OTHER DEPARTMENTS	\$17,467,000	\$9,369,000	\$8,098,000
L. OTHER	\$87,929,000	\$74,770,500	\$13,158,500
M. TOTAL CHANGE	<u>\$29,785,337,910</u>	<u>\$20,748,220,440</u>	<u>\$9,037,117,470</u>
<b>III. TOTAL MEDI-CAL ESTIMATE</b>	<u><u>\$69,725,262,400</u></u>	<u><u>\$42,776,424,640</u></u>	<u><u>\$26,948,837,770</u></u>

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b><u>ELIGIBILITY</u></b>				
1	TRANSITION OF HFP TO MEDI-CAL	\$1,266,927,000	\$823,502,550	\$443,424,450
2	FAMILY PACT PROGRAM	\$656,141,000	\$491,798,900	\$164,342,100
3	BREAST AND CERVICAL CANCER TREATMENT	\$163,528,000	\$92,098,350	\$71,429,650
4	AIM LINKED INFANTS 250-300% FPL	\$33,357,000	\$21,682,050	\$11,674,950
5	MEDI-CAL ADULT INMATE PROGRAMS	\$10,827,000	\$10,827,000	\$0
6	CHDP GATEWAY - PREENROLLMENT	\$12,786,000	\$8,310,900	\$4,475,100
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM	\$5,517,000	\$5,517,000	\$0
8	REFUGEES	\$6,475,000	\$0	\$6,475,000
9	MCHA VS. DHCS AND MRMIB	\$42,800	\$21,400	\$21,400
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$2,409,000	\$1,476,000	\$933,000
11	NEW QUALIFIED IMMIGRANTS	\$0	-\$63,554,000	\$63,554,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	\$57,988,650	-\$57,988,650
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	\$8,901,500	-\$8,901,500
14	INCARCERATION VERIFICATION PROGRAM	-\$264,970	-\$132,480	-\$132,480
15	PARIS-FEDERAL	-\$1,734,230	-\$867,120	-\$867,120
16	PARIS-VETERANS	-\$2,290,470	-\$1,145,240	-\$1,145,240
17	PARIS-INTERSTATE	-\$7,760,810	-\$3,880,410	-\$3,880,410
212	AIM LINKED MOTHERS 200-300% FPL	\$128,655,000	\$71,196,000	\$57,459,000
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$2,274,614,320</b>	<b>\$1,523,741,060</b>	<b>\$750,873,260</b>
<b><u>AFFORDABLE CARE ACT</u></b>				
18	ACA OPTIONAL EXPANSION	\$6,586,221,000	\$6,586,221,000	\$0
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$602,426,830	\$575,216,250	\$27,210,580
20	COMMUNITY FIRST CHOICE OPTION	\$219,412,000	\$219,412,000	\$0
21	ACA MANDATORY EXPANSION	\$867,333,000	\$448,118,050	\$419,214,950
22	MENTAL HEALTH SERVICES EXPANSION	\$300,000,000	\$181,000,000	\$119,000,000
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COS	\$49,922,000	\$49,922,000	\$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$78,784,000	\$41,034,500	\$37,749,500
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	\$56,924,000	\$36,286,000	\$20,638,000
27	USPSTF GRADE A AND B RECOMMENDATIONS	\$70,186,000	\$43,805,500	\$26,380,500
28	ACA DELAY OF REDETERMINATIONS	\$668,000	\$462,200	\$205,800
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	\$26,950,000	-\$26,950,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$98,220	-\$49,110	-\$49,110
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION	-\$17,113,000	-\$8,556,500	-\$8,556,500
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION	-\$47,601,000	-\$32,623,000	-\$14,978,000
34	MANAGED CARE DRUG REBATES	-\$292,429,000	-\$146,214,500	-\$146,214,500
205	HEALTH INSURER FEE	\$121,306,000	\$66,718,500	\$54,587,500
206	ACA EXPRESS LANE ENROLLMENT	\$687,214,000	\$675,627,850	\$11,586,150

Costs shown include application of payment lag and percent reflected in base calculation.

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b><u>AFFORDABLE CARE ACT</u></b>				
210	ACA EXPANSION-PREGNANCY ONLY	-\$33,145,000	-\$16,572,500	-\$16,572,500
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$9,250,010,600</b>	<b>\$8,746,758,230</b>	<b>\$503,252,370</b>
<b><u>BENEFITS</u></b>				
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$256,044,000	\$256,044,000	\$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$145,124,000	\$145,124,000	\$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$24,679,000	\$21,972,000	\$2,707,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFIT	\$239,531,000	\$166,590,000	\$72,941,000
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$20,232,000
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILC	\$34,170,000	\$17,085,000	\$17,085,000
41	YOUTH REGIONAL TREATMENT CENTERS	\$6,345,000	\$6,311,000	\$34,000
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCF	\$4,841,000	\$2,420,500	\$2,420,500
43	CCT FUND TRANSFER TO CDSS AND CDDS	\$3,415,000	\$3,415,000	\$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$540,000	\$270,000	\$270,000
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$501,000	\$501,000	\$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$141,000	\$141,000	\$0
47	INCREASED FEDERAL MATCHING FUNDS FOR FPAC	\$0	\$693,940	-\$693,940
48	HEARING AID CAP	\$0	\$0	\$0
49	SCHIP FUNDING FOR PRENATAL CARE	\$0	\$92,051,700	-\$92,051,700
50	COPAYMENT FOR NON-EMERGENCY ER VISITS	-\$33,707,000	-\$16,853,500	-\$16,853,500
51	WOMEN'S HEALTH SERVICES	-\$10,351,000	-\$7,976,100	-\$2,374,900
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$18,163,000	-\$9,081,500	-\$9,081,500
	<b>BENEFITS SUBTOTAL</b>	<b>\$693,574,000</b>	<b>\$698,940,040</b>	<b>-\$5,366,040</b>
<b><u>PHARMACY</u></b>				
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	\$28,892,000	\$14,446,000	\$14,446,000
54	NON FFP DRUGS	\$0	-\$2,077,000	\$2,077,000
55	BCCTP DRUG REBATES	-\$15,764,000	-\$10,246,600	-\$5,517,400
56	MEDICAL SUPPLY REBATES	-\$18,321,000	-\$9,160,500	-\$9,160,500
57	FAMILY PACT DRUG REBATES	-\$74,815,000	-\$65,235,500	-\$9,579,500
59	AGED AND DISPUTED DRUG REBATES	-\$150,000,000	-\$75,388,800	-\$74,611,200
60	STATE SUPPLEMENTAL DRUG REBATES	-\$180,941,000	-\$90,939,700	-\$90,001,300
61	FEDERAL DRUG REBATE PROGRAM	-\$1,457,217,000	-\$788,385,700	-\$668,831,300
211	MCO SUPPLEMENTAL DRUG REBATE	-\$65,000,000	-\$32,500,000	-\$32,500,000
	<b>PHARMACY SUBTOTAL</b>	<b>-\$1,933,166,000</b>	<b>-\$1,059,487,800</b>	<b>-\$873,678,200</b>
<b><u>DRUG MEDI-CAL</u></b>				
66	VOLUNTARY INPATIENT DETOXIFICATION	\$23,663,000	\$13,723,000	\$9,940,000
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$3,036,000	\$0

Costs shown include application of payment lag and percent reflected in base calculation.

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b><u>DRUG MEDI-CAL</u></b>				
68	ANNUAL RATE ADJUSTMENT	-\$2,607,000	-\$2,359,000	-\$248,000
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$24,092,000</b>	<b>\$14,400,000</b>	<b>\$9,692,000</b>
<b><u>MENTAL HEALTH</u></b>				
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	\$107,898,000	\$107,898,000	\$0
72	ELIMINATION OF STATE MAXIMUM RATES	\$133,477,000	\$133,477,000	\$0
73	TRANSITION OF HFP - SMH SERVICES	\$41,938,000	\$41,938,000	\$0
74	KATIE A. V. DIANA BONTA	\$26,751,000	\$26,751,000	\$0
75	HEALTHY FAMILIES - SED	\$18,307,000	\$18,307,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$24,800,000	\$24,800,000	\$0
77	OVER ONE-YEAR CLAIMS	\$3,000,000	\$3,000,000	\$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	\$2,270,000	\$2,270,000	\$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPA	\$0	\$0	\$0
80	IMD ANCILLARY SERVICES	\$0	-\$6,000,000	\$6,000,000
81	CHART REVIEW	-\$418,000	-\$418,000	\$0
82	REIMBURSEMENT IN IMD ANCILLARY SERVICES CO:	-\$12,000,000	\$0	-\$12,000,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$346,023,000</b>	<b>\$352,023,000</b>	<b>-\$6,000,000</b>
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>				
85	MH/UCD & BTR—DSH PAYMENT	\$1,702,746,000	\$1,166,861,000	\$535,885,000
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	\$1,892,310,000	\$946,155,000	\$946,155,000
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEN	\$534,994,000	\$267,497,000	\$267,497,000
88	BTR—SAFETY NET CARE POOL	\$242,250,000	\$242,250,000	\$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	\$243,001,000	\$121,500,500	\$121,500,500
91	MH/UCD & BTR—CCS AND GHPP	\$119,676,000	\$119,676,000	\$0
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COS	\$82,000,000	\$82,000,000	\$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	\$53,645,000	\$255,942,000	-\$202,297,000
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$102,004,940	\$51,002,470	\$51,002,470
99	MH/UCD—STABILIZATION FUNDING	\$7,595,000	\$0	\$7,595,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	\$108,328,000	\$108,328,000	\$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HI	\$536,000	\$536,000	\$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$3,802,000	\$1,901,000	\$1,901,000
104	MH/UCD—SAFETY NET CARE POOL	\$35,917,000	\$35,917,000	\$0
105	MH/UCD & BTR—MIA-LTC	\$0	\$20,118,000	-\$20,118,000
106	MH/UCD & BTR—BCCTP	\$0	\$2,179,000	-\$2,179,000
107	MH/UCD & BTR—DPH INTERIM RATE	\$0	\$491,392,000	-\$491,392,000
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLO	-\$196,502,220	-\$98,251,110	-\$98,251,110
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$4,932,302,730</b>	<b>\$3,815,003,860</b>	<b>\$1,117,298,860</b>

Costs shown include application of payment lag and percent reflected in base calculation.

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

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>				
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$1,252,660,000	\$735,873,500	\$516,786,500
118	MANAGED CARE RATE RANGE IGTS	\$820,130,000	\$428,681,000	\$391,449,000
119	TRANSITION OF DUAL ELIGIBLES-MANAGED CARE P	\$5,706,904,000	\$2,901,921,500	\$2,804,982,500
120	MANAGED CARE PUBLIC HOSPITAL IGTS	\$399,710,000	\$199,855,000	\$199,855,000
123	TRANSFER OF IHSS COSTS TO CDSS	\$1,615,660,000	\$0	\$1,615,660,000
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	-\$16,426,000	-\$8,213,000	-\$8,213,000
131	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$0	\$2,000,000
132	CAPITATED RATE ADJUSTMENT FOR FY 2014-15	\$465,411,000	\$233,592,800	\$231,818,200
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0
136	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0
138	FFS COSTS FOR MANAGED CARE ENROLLEES	\$0	\$0	\$0
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMEI	\$0	\$0	\$0
140	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0
141	SCAN TRANSITION TO MANAGED CARE	\$0	\$0	\$0
143	TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE	-\$3,788,843,000	-\$1,894,421,500	-\$1,894,421,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$6,457,206,000</b>	<b>\$2,597,289,300</b>	<b>\$3,859,916,700</b>
<b>PROVIDER RATES</b>				
24	AB 1629 ADD-ONS	\$17,026,790	\$8,513,400	\$8,513,400
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$203,110,380	\$101,555,190	\$101,555,190
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$187,060,400	\$93,530,200	\$93,530,200
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	\$42,657,000	\$21,328,500	\$21,328,500
147	AIR AMBULANCE MEDICAL TRANSPORTATION	\$14,611,970	\$7,305,100	\$7,306,880
148	LTC RATE ADJUSTMENT	\$98,236,590	\$49,118,290	\$49,118,290
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$14,425,830	\$7,212,920	\$7,212,910
150	HOSPICE RATE INCREASES	\$11,029,170	\$5,514,590	\$5,514,590
151	LONG TERM CARE QUALITY ASSURANCE FUND EXP	\$0	\$0	\$0
152	NON-AB 1629 LTC RATE FREEZE	-\$35,022,000	-\$17,511,000	-\$17,511,000
154	LABORATORY RATE METHODOLOGY CHANGE	-\$14,715,900	-\$7,357,950	-\$7,357,950
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$33,981,950	-\$16,990,980	-\$16,990,980
156	REDUCTION TO RADIOLOGY RATES	-\$60,399,470	-\$30,199,740	-\$30,199,740
157	10% PROVIDER PAYMENT REDUCTION	-\$467,086,540	-\$233,543,270	-\$233,543,270
	<b>PROVIDER RATES SUBTOTAL</b>	<b>-\$23,047,730</b>	<b>-\$11,524,750</b>	<b>-\$11,522,980</b>
<b>SUPPLEMENTAL PMNTS.</b>				
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$7,024,244,000	\$3,484,560,000	\$3,539,684,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	\$66,000,000	\$66,000,000	\$0
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$50,000,000	\$50,000,000	\$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT	\$186,774,000	\$186,774,000	\$0

Costs shown include application of payment lag and percent reflected in base calculation.

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b><u>SUPPLEMENTAL PMNTS.</u></b>				
163	NDPH IGT SUPPLEMENTAL PAYMENTS	\$70,000,000	\$35,000,000	\$35,000,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	\$43,658,000	\$43,658,000	\$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	\$110,857,000	\$65,646,000	\$45,211,000
166	FFP FOR LOCAL TRAUMA CENTERS	\$70,000,000	\$35,000,000	\$35,000,000
167	IGT PAYMENTS FOR HOSPITAL SERVICES	\$15,000,000	\$7,500,000	\$7,500,000
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSI	\$10,000,000	\$5,000,000	\$5,000,000
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRI	\$8,000,000	\$4,000,000	\$4,000,000
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEN	\$3,800,000	\$3,800,000	\$0
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$7,658,333,000</b>	<b>\$3,986,938,000</b>	<b>\$3,671,395,000</b>
<b><u>OTHER DEPARTMENTS</u></b>				
208	DENTAL CHILDREN'S OUTREACH AGES 0-3	\$17,467,000	\$9,369,000	\$8,098,000
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$17,467,000</b>	<b>\$9,369,000</b>	<b>\$8,098,000</b>
<b><u>OTHER</u></b>				
177	ARRA HITECH - PROVIDER PAYMENTS	\$151,719,000	\$151,719,000	\$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- C	\$88,060,000	\$88,060,000	\$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	\$8,501,000	\$4,250,500	\$4,250,500
184	CDDS DENTAL SERVICES	\$11,430,000	\$0	\$11,430,000
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDC	\$16,415,000	\$9,934,000	\$6,481,000
187	AUDIT SETTLEMENTS	\$627,000	\$0	\$627,000
191	INDIAN HEALTH SERVICES	\$2,180,000	\$11,615,500	-\$9,435,500
192	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0
193	ANTI-FRAUD ACTIVITIES	\$0	\$0	\$0
194	CLPP FUND	\$0	\$0	\$0
196	AB 97 INJUNCTIONS	\$0	\$0	\$0
197	TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0
199	RECOVERY OF PCS/IHSS	-\$389,000	-\$194,500	-\$194,500
200	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$0	\$0	\$0
201	IHSS REDUCTION IN SERVICE HOURS	-\$190,614,000	-\$190,614,000	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$87,929,000</b>	<b>\$74,770,500</b>	<b>\$13,158,500</b>
	<b>GRAND TOTAL</b>	<b>\$29,785,337,920</b>	<b>\$20,748,220,440</b>	<b>\$9,037,117,480</b>

Costs shown include application of payment lag and percent reflected in base calculation.

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY  
FISCAL YEAR 2014-15**

<u>SERVICE CATEGORY</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<b>PROFESSIONAL</b>	\$6,272,051,330	\$3,932,868,560	\$2,339,182,770
PHYSICIANS	\$1,135,237,760	\$776,283,460	\$358,954,300
OTHER MEDICAL	\$3,339,772,300	\$2,146,434,060	\$1,193,338,230
COUNTY OUTPATIENT	\$146,378,330	\$118,392,230	\$27,986,100
COMMUNITY OUTPATIENT	\$1,650,662,940	\$891,758,810	\$758,904,130
<b>PHARMACY</b>	\$585,242,620	\$417,594,090	\$167,648,530
<b>HOSPITAL INPATIENT</b>	\$10,546,984,350	\$6,575,474,300	\$3,971,510,050
COUNTY INPATIENT	\$2,309,793,940	\$1,903,080,770	\$406,713,170
COMMUNITY INPATIENT	\$8,237,190,410	\$4,672,393,530	\$3,564,796,880
<b>LONG TERM CARE</b>	\$3,469,473,320	\$1,768,485,650	\$1,700,987,670
NURSING FACILITIES	\$3,230,262,200	\$1,645,771,410	\$1,584,490,790
ICF-DD	\$239,211,120	\$122,714,240	\$116,496,880
<b>OTHER SERVICES</b>	\$827,094,470	\$456,618,430	\$370,476,050
MEDICAL TRANSPORTATION	\$183,217,080	\$121,797,250	\$61,419,840
OTHER SERVICES	\$444,256,420	\$229,607,120	\$214,649,300
HOME HEALTH	\$199,620,970	\$105,214,060	\$94,406,910
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$21,700,846,100</b>	<b>\$13,151,041,030</b>	<b>\$8,549,805,070</b>
<b>MANAGED CARE</b>	\$34,013,370,910	\$19,605,795,150	\$14,407,575,760
TWO PLAN MODEL	\$21,568,025,340	\$12,326,959,000	\$9,241,066,340
COUNTY ORGANIZED HEALTH SYS	\$8,243,429,040	\$4,926,324,650	\$3,317,104,380
GEOGRAPHIC MANAGED CARE	\$3,427,710,390	\$1,964,848,880	\$1,462,861,510
PHP & OTHER MANAG. CARE	\$774,206,140	\$387,662,610	\$386,543,530
<b>DENTAL</b>	\$892,390,710	\$525,729,890	\$366,660,810
<b>MENTAL HEALTH</b>	\$1,929,833,090	\$1,882,158,800	\$47,674,290
<b>AUDITS/ LAWSUITS</b>	\$4,565,870	\$974,330	\$3,591,540
<b>EPSDT SCREENS</b>	\$36,969,910	\$18,863,920	\$18,105,990
<b>MEDICARE PAYMENTS</b>	\$4,155,206,000	\$1,262,968,500	\$2,892,237,500
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$265,354,240	\$265,333,950	\$20,280
<b>MISC. SERVICES</b>	\$6,981,973,590	\$6,190,330,060	\$791,643,520
<b>RECOVERIES</b>	-\$255,248,000	-\$126,771,000	-\$128,477,000
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$69,725,262,400</b>	<b>\$42,776,424,640</b>	<b>\$26,948,837,770</b>

**MEDI-CAL EXPENDITURES BY SERVICE CATEGORY  
CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2013-14 AND 2014-15**

<u>SERVICE CATEGORY</u>	<u>NOV. 2013 EST. FOR 2013-14</u>	<u>NOV. 2013 EST. FOR 2014-15</u>	<u>DOLLAR DIFFERENCE</u>	<u>% CHANGE</u>
<b>PROFESSIONAL</b>	\$6,315,862,270	\$6,272,051,330	-\$43,810,940	-0.69
PHYSICIANS	\$1,405,588,020	\$1,135,237,760	-\$270,350,260	-19.23
OTHER MEDICAL	\$3,441,882,160	\$3,339,772,300	-\$102,109,870	-2.97
COUNTY OUTPATIENT	\$142,407,890	\$146,378,330	\$3,970,440	2.79
COMMUNITY OUTPATIENT	\$1,325,984,200	\$1,650,662,940	\$324,678,740	24.49
<b>PHARMACY</b>	\$995,111,040	\$585,242,620	-\$409,868,420	-41.19
<b>HOSPITAL INPATIENT</b>	\$10,263,884,270	\$10,546,984,350	\$283,100,080	2.76
COUNTY INPATIENT	\$2,094,292,860	\$2,309,793,940	\$215,501,090	10.29
COMMUNITY INPATIENT	\$8,169,591,420	\$8,237,190,410	\$67,598,990	0.83
<b>LONG TERM CARE</b>	\$4,977,079,390	\$3,469,473,320	-\$1,507,606,070	-30.29
NURSING FACILITIES	\$4,592,061,550	\$3,230,262,200	-\$1,361,799,350	-29.66
ICF-DD	\$385,017,840	\$239,211,120	-\$145,806,720	-37.87
<b>OTHER SERVICES</b>	\$1,191,783,270	\$827,094,470	-\$364,688,800	-30.60
MEDICAL TRANSPORTATION	\$353,294,870	\$183,217,080	-\$170,077,780	-48.14
OTHER SERVICES	\$589,510,840	\$444,256,420	-\$145,254,410	-24.64
HOME HEALTH	\$248,977,570	\$199,620,970	-\$49,356,600	-19.82
<b>TOTAL FEE-FOR-SERVICE</b>	<b>\$23,743,720,250</b>	<b>\$21,700,846,100</b>	<b>-\$2,042,874,150</b>	<b>-8.60</b>
<b>MANAGED CARE</b>	\$23,231,037,950	\$34,013,370,910	\$10,782,332,960	46.41
TWO PLAN MODEL	\$13,902,387,070	\$21,568,025,340	\$7,665,638,270	55.14
COUNTY ORGANIZED HEALTH SYSTEMS	\$6,443,040,490	\$8,243,429,040	\$1,800,388,550	27.94
GEOGRAPHIC MANAGED CARE	\$2,321,861,310	\$3,427,710,390	\$1,105,849,080	47.63
PHP & OTHER MANAG. CARE	\$563,749,090	\$774,206,140	\$210,457,050	37.33
<b>DENTAL</b>	\$632,838,310	\$892,390,710	\$259,552,390	41.01
<b>MENTAL HEALTH</b>	\$1,796,083,700	\$1,929,833,090	\$133,749,380	7.45
<b>AUDITS/ LAWSUITS</b>	-\$69,007,390	\$4,565,870	\$73,573,250	-106.62
<b>EPSDT SCREENS</b>	\$37,239,130	\$36,969,910	-\$269,220	-0.72
<b>MEDICARE PAYMENTS</b>	\$4,037,588,000	\$4,155,206,000	\$117,618,000	2.91
<b>STATE HOSP./DEVELOPMENTAL CNTRS.</b>	\$262,208,690	\$265,354,240	\$3,145,540	1.20
<b>MISC. SERVICES</b>	\$12,232,288,220	\$6,981,973,590	-\$5,250,314,630	-42.92
<b>RECOVERIES</b>	-\$262,990,000	-\$255,248,000	\$7,742,000	-2.94
<b>GRAND TOTAL MEDI-CAL</b>	<b>\$65,641,006,870</b>	<b>\$69,725,262,400</b>	<b>\$4,084,255,530</b>	<b>6.22</b>
<b>STATE FUNDS</b>	<b>\$25,081,180,330</b>	<b>\$26,948,837,770</b>	<b>\$1,867,657,440</b>	<b>7.45</b>

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>							
1	TRANSITION OF HFP TO MEDI-CAL	\$1,195,670,000	\$418,484,500	\$1,266,927,000	\$443,424,450	\$71,257,000	\$24,939,950
2	FAMILY PACT PROGRAM	\$632,717,000	\$158,474,900	\$656,141,000	\$164,342,100	\$23,424,000	\$5,867,200
3	BREAST AND CERVICAL CANCER TREATMENT	\$154,126,000	\$67,664,450	\$163,528,000	\$71,429,650	\$9,402,000	\$3,765,200
4	AIM LINKED INFANTS 250-300% FPL	\$33,357,000	\$11,674,950	\$33,357,000	\$11,674,950	\$0	\$0
5	MEDI-CAL ADULT INMATE PROGRAMS	\$12,557,000	\$0	\$10,827,000	\$0	-\$1,730,000	\$0
6	CHDP GATEWAY - PREENROLLMENT	\$11,937,000	\$4,177,950	\$12,786,000	\$4,475,100	\$849,000	\$297,150
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	\$6,467,000	\$0	\$5,517,000	\$0	-\$950,000	\$0
8	REFUGEES	\$5,887,000	\$5,887,000	\$6,475,000	\$6,475,000	\$588,000	\$588,000
9	MCHA VS. DHCS AND MRMB	\$540,000	\$270,000	\$234,000	\$117,000	-\$306,000	-\$153,000
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	\$0	\$0	\$2,409,000	\$933,000	\$2,409,000	\$933,000
11	NEW QUALIFIED IMMIGRANTS	\$0	\$63,554,000	\$0	\$63,554,000	\$0	\$0
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	\$0	-\$56,409,300	\$0	-\$57,988,650	\$0	-\$1,579,350
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	\$0	-\$8,901,500	\$0	-\$8,901,500	\$0	\$0
14	INCARCERATION VERIFICATION PROGRAM	-\$211,000	-\$105,500	-\$348,000	-\$174,000	-\$137,000	-\$68,500
15	PARIS-FEDERAL	-\$7,682,000	-\$3,841,000	-\$10,725,000	-\$5,362,500	-\$3,043,000	-\$1,521,500
16	PARIS-VETERANS	-\$3,542,510	-\$1,771,260	-\$3,547,820	-\$1,773,910	-\$5,310	-\$2,650
17	PARIS-INTERSTATE	-\$26,010,000	-\$13,005,000	-\$38,477,000	-\$19,238,500	-\$12,467,000	-\$6,233,500
212	AIM LINKED MOTHERS 200-300% FPL	\$0	\$0	\$128,655,000	\$57,459,000	\$128,655,000	\$57,459,000
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$2,015,812,490</b>	<b>\$646,154,190</b>	<b>\$2,233,758,180</b>	<b>\$730,445,190</b>	<b>\$217,945,690</b>	<b>\$84,291,000</b>
<b>AFFORDABLE CARE ACT</b>							
18	ACA OPTIONAL EXPANSION	\$2,609,318,000	\$0	\$6,586,221,000	\$0	\$3,976,903,000	\$0
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	\$1,661,805,710	\$33,670,960	\$602,426,830	\$27,210,580	-\$1,059,378,890	-\$6,460,380
20	COMMUNITY FIRST CHOICE OPTION	\$238,923,000	\$0	\$219,412,000	\$0	-\$19,511,000	\$0
21	ACA MANDATORY EXPANSION	\$222,825,000	\$103,754,350	\$867,333,000	\$419,214,950	\$644,508,000	\$315,460,600
22	MENTAL HEALTH SERVICES EXPANSION	\$73,695,000	\$28,427,000	\$300,000,000	\$119,000,000	\$226,305,000	\$90,573,000

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>AFFORDABLE CARE ACT</u></b>							
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	\$24,252,000	\$0	\$49,922,000	\$0	\$25,670,000	\$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$18,672,000	\$9,168,500	\$78,784,000	\$37,749,500	\$60,112,000	\$28,581,000
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	\$14,493,000	\$5,254,000	\$56,924,000	\$20,638,000	\$42,431,000	\$15,384,000
27	USPSTF GRADE A AND B RECOMMENDATIONS	\$9,673,000	\$3,711,000	\$70,186,000	\$26,380,500	\$60,513,000	\$22,669,500
28	ACA DELAY OF REDETERMINATIONS	\$6,653,000	\$2,052,850	\$668,000	\$205,800	-\$5,985,000	-\$1,847,050
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$796,000	\$796,000	\$0	\$0	-\$796,000	-\$796,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	\$0	-\$40,284,000	\$0	-\$26,950,000	\$0	\$13,334,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-\$10,530	-\$5,270	-\$98,220	-\$49,110	-\$87,690	-\$43,850
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION	-\$15,687,000	-\$7,843,500	-\$17,113,000	-\$8,556,500	-\$1,426,000	-\$713,000
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION	-\$43,634,000	-\$13,730,000	-\$47,601,000	-\$14,978,000	-\$3,967,000	-\$1,248,000
34	MANAGED CARE DRUG REBATES	-\$388,347,000	-\$194,173,500	-\$292,429,000	-\$146,214,500	\$95,918,000	\$47,959,000
205	HEALTH INSURER FEE	\$0	\$0	\$121,306,000	\$54,587,500	\$121,306,000	\$54,587,500
206	ACA EXPRESS LANE ENROLLMENT	\$71,535,000	\$1,204,400	\$687,214,000	\$11,586,150	\$615,679,000	\$10,381,750
210	ACA EXPANSION-PREGNANCY ONLY	\$0	\$0	-\$33,145,000	-\$16,572,500	-\$33,145,000	-\$16,572,500
	<b>AFFORDABLE CARE ACT SUBTOTAL</b>	<b>\$4,504,962,180</b>	<b>-\$67,997,210</b>	<b>\$9,250,010,600</b>	<b>\$503,252,370</b>	<b>\$4,745,048,420</b>	<b>\$571,249,580</b>
<b><u>BENEFITS</u></b>							
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	\$206,024,000	\$0	\$256,044,000	\$0	\$50,020,000	\$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	\$145,537,000	\$0	\$145,124,000	\$0	-\$413,000	\$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	\$51,410,000	\$1,474,000	\$24,679,000	\$2,707,000	-\$26,731,000	\$1,233,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFITS	\$10,888,000	\$3,315,500	\$239,531,000	\$72,941,000	\$228,643,000	\$69,625,500
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	\$40,464,000	\$20,232,000	\$40,464,000	\$20,232,000	\$0	\$0
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS	\$39,990,000	\$19,995,000	\$34,170,000	\$17,085,000	-\$5,820,000	-\$2,910,000
41	YOUTH REGIONAL TREATMENT CENTERS	\$5,085,000	\$776,000	\$6,345,000	\$34,000	\$1,260,000	-\$742,000
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREI	\$4,631,000	\$2,315,500	\$4,841,000	\$2,420,500	\$210,000	\$105,000
43	CCT FUND TRANSFER TO CDSS AND CDDS	\$2,678,000	\$0	\$3,415,000	\$0	\$737,000	\$0

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>BENEFITS</u></b>							
44	PEDIATRIC PALLIATIVE CARE WAIVER	\$540,000	\$270,000	\$540,000	\$270,000	\$0	\$0
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	\$183,000	\$0	\$501,000	\$0	\$318,000	\$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	\$131,000	\$0	\$141,000	\$0	\$10,000	\$0
47	INCREASED FEDERAL MATCHING FUNDS FOR FPACT	\$0	-\$3,794,100	\$0	-\$3,794,100	\$0	\$0
48	HEARING AID CAP	-\$1,434,000	-\$717,000	-\$1,434,000	-\$717,000	\$0	\$0
49	SCHIP FUNDING FOR PRENATAL CARE	\$0	-\$92,051,700	\$0	-\$92,051,700	\$0	\$0
50	COPAYMENT FOR NON-EMERGENCY ER VISITS	\$0	\$0	-\$33,707,000	-\$16,853,500	-\$33,707,000	-\$16,853,500
51	WOMEN'S HEALTH SERVICES	-\$8,289,990	-\$3,398,820	-\$10,351,000	-\$2,374,900	-\$2,061,010	\$1,023,920
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-\$13,558,000	-\$6,779,000	-\$18,163,000	-\$9,081,500	-\$4,605,000	-\$2,302,500
	<b>BENEFITS SUBTOTAL</b>	<b>\$484,279,010</b>	<b>-\$58,362,620</b>	<b>\$692,140,000</b>	<b>-\$9,183,200</b>	<b>\$207,860,990</b>	<b>\$49,179,420</b>
<b><u>PHARMACY</u></b>							
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	\$3,356,000	\$1,678,000	\$28,892,000	\$14,446,000	\$25,536,000	\$12,768,000
54	NON FFP DRUGS	\$0	\$1,920,000	\$0	\$2,077,000	\$0	\$157,000
55	BCCTP DRUG REBATES	-\$15,389,000	-\$5,386,150	-\$15,764,000	-\$5,517,400	-\$375,000	-\$131,250
56	MEDICAL SUPPLY REBATES	-\$18,321,000	-\$9,160,500	-\$18,321,000	-\$9,160,500	\$0	\$0
57	FAMILY PACT DRUG REBATES	-\$72,232,000	-\$9,248,400	-\$74,815,000	-\$9,579,500	-\$2,583,000	-\$331,100
58	LITIGATION SETTLEMENTS	-\$81,772,000	-\$81,772,000	\$0	\$0	\$81,772,000	\$81,772,000
59	AGED AND DISPUTED DRUG REBATES	-\$150,000,000	-\$74,611,200	-\$150,000,000	-\$74,611,200	\$0	\$0
60	STATE SUPPLEMENTAL DRUG REBATES	-\$165,789,000	-\$82,464,900	-\$180,941,000	-\$90,001,300	-\$15,152,000	-\$7,536,400
61	FEDERAL DRUG REBATE PROGRAM	-\$1,335,187,000	-\$608,132,700	-\$1,457,217,000	-\$668,831,300	-\$122,030,000	-\$60,698,600
211	MCO SUPPLEMENTAL DRUG REBATE	\$0	\$0	-\$65,000,000	-\$32,500,000	-\$65,000,000	-\$32,500,000
	<b>PHARMACY SUBTOTAL</b>	<b>-\$1,835,334,000</b>	<b>-\$867,177,850</b>	<b>-\$1,933,166,000</b>	<b>-\$873,678,200</b>	<b>-\$97,832,000</b>	<b>-\$6,500,350</b>
<b><u>DRUG MEDI-CAL</u></b>							
66	VOLUNTARY INPATIENT DETOXIFICATION	\$9,468,000	\$4,030,000	\$23,663,000	\$9,940,000	\$14,195,000	\$5,910,000
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	\$3,036,000	\$0	\$3,036,000	\$0	\$0	\$0

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CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2013-14 AND 2014-15**

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>DRUG MEDI-CAL</u></b>							
68	ANNUAL RATE ADJUSTMENT	\$0	\$0	-\$2,607,000	-\$248,000	-\$2,607,000	-\$248,000
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$12,504,000</b>	<b>\$4,030,000</b>	<b>\$24,092,000</b>	<b>\$9,692,000</b>	<b>\$11,588,000</b>	<b>\$5,662,000</b>
<b><u>MENTAL HEALTH</u></b>							
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	\$293,819,000	\$0	\$107,898,000	\$0	-\$185,921,000	\$0
72	ELIMINATION OF STATE MAXIMUM RATES	\$124,190,000	\$0	\$133,477,000	\$0	\$9,287,000	\$0
73	TRANSITION OF HFP - SMH SERVICES	\$32,619,000	\$0	\$41,938,000	\$0	\$9,319,000	\$0
74	KATIE A. V. DIANA BONTA	\$27,955,000	\$0	\$26,751,000	\$0	-\$1,204,000	\$0
75	HEALTHY FAMILIES - SED	\$18,731,000	\$0	\$18,307,000	\$0	-\$424,000	\$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	\$12,400,000	\$0	\$24,800,000	\$0	\$12,400,000	\$0
77	OVER ONE-YEAR CLAIMS	\$3,000,000	\$0	\$3,000,000	\$0	\$0	\$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	\$2,270,000	\$0	\$2,270,000	\$0	\$0	\$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	\$0	\$7,204,000	\$0	\$0	\$0	-\$7,204,000
80	IMD ANCILLARY SERVICES	\$0	\$6,000,000	\$0	\$6,000,000	\$0	\$0
81	CHART REVIEW	-\$1,475,000	\$0	-\$418,000	\$0	\$1,057,000	\$0
82	REIMBURSEMENT IN IMD ANCILLARY SERVICES COST:	-\$12,000,000	-\$12,000,000	-\$12,000,000	-\$12,000,000	\$0	\$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-\$41,760,000	\$27,777,000	\$0	\$0	\$41,760,000	-\$27,777,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$459,749,000</b>	<b>\$28,981,000</b>	<b>\$346,023,000</b>	<b>-\$6,000,000</b>	<b>-\$113,726,000</b>	<b>-\$34,981,000</b>
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>							
84	BTR - LIHP - MCE	\$5,495,397,000	\$2,338,785,500	\$0	\$0	-\$5,495,397,000	-\$2,338,785,500
85	MH/UCD & BTR—DSH PAYMENT	\$1,599,070,000	\$344,527,000	\$1,702,746,000	\$535,885,000	\$103,676,000	\$191,358,000
86	BTR—DPH DELIVERY SYSTEM REFORM INCENTIVE PC	\$1,485,648,000	\$742,824,000	\$1,892,310,000	\$946,155,000	\$406,662,000	\$203,331,000
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEME	\$603,508,000	\$301,754,000	\$534,994,000	\$267,497,000	-\$68,514,000	-\$34,257,000
88	BTR—SAFETY NET CARE POOL	\$317,250,000	\$0	\$242,250,000	\$0	-\$75,000,000	\$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL F	\$248,602,000	\$124,301,000	\$243,001,000	\$121,500,500	-\$5,601,000	-\$2,800,500
90	BTR—LOW INCOME HEALTH PROGRAM - HCCI	\$180,186,000	\$44,904,000	\$0	\$0	-\$180,186,000	-\$44,904,000

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CURRENT YEAR COMPARED TO BUDGET YEAR  
FISCAL YEARS 2013-14 AND 2014-15**

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>							
91	MH/UCD & BTR—CCS AND GHPP	\$129,858,000	\$0	\$119,676,000	\$0	-\$10,182,000	\$0
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	\$110,000,000	\$55,000,000	\$0	\$0	-\$110,000,000	-\$55,000,000
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	\$100,000,000	\$50,000,000	\$0	\$0	-\$100,000,000	-\$50,000,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	\$82,000,000	\$0	\$82,000,000	\$0	\$0	\$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	\$66,339,000	-\$331,197,000	\$53,645,000	-\$202,297,000	-\$12,694,000	\$128,900,000
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMA	\$56,473,000	\$0	\$0	\$0	-\$56,473,000	\$0
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	\$48,791,390	\$24,395,690	\$108,297,000	\$54,148,500	\$59,505,610	\$29,752,810
98	BTR—INCREASE SAFETY NET CARE POOL	\$30,750,000	\$0	\$0	\$0	-\$30,750,000	\$0
99	MH/UCD—STABILIZATION FUNDING	\$13,988,000	\$13,988,000	\$7,595,000	\$7,595,000	-\$6,393,000	-\$6,393,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	\$11,877,000	\$0	\$108,328,000	\$0	\$96,451,000	\$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	\$10,193,000	\$0	\$536,000	\$0	-\$9,657,000	\$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	\$9,613,000	\$0	\$0	\$0	-\$9,613,000	\$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	\$8,510,000	\$4,255,000	\$3,802,000	\$1,901,000	-\$4,708,000	-\$2,354,000
104	MH/UCD—SAFETY NET CARE POOL	\$1,949,000	\$0	\$35,917,000	\$0	\$33,968,000	\$0
105	MH/UCD & BTR—MIA-LTC	\$0	-\$19,327,000	\$0	-\$20,118,000	\$0	-\$791,000
106	MH/UCD & BTR—BCCTP	\$0	-\$1,786,000	\$0	-\$2,179,000	\$0	-\$393,000
107	MH/UCD & BTR—DPH INTERIM RATE	\$0	-\$441,435,000	\$0	-\$491,392,000	\$0	-\$49,957,000
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGR	\$0	-\$30,750,000	\$0	\$0	\$0	\$30,750,000
109	HOSPITAL STABILIZATION	\$0	\$0	\$0	\$0	\$0	\$0
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	\$0	-\$20,762,000	\$0	\$0	\$0	\$20,762,000
111	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS	\$0	\$0	\$0	\$0	\$0	\$0
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER	-\$61,500,000	\$0	\$0	\$0	\$61,500,000	\$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-\$77,897,380	-\$38,948,690	-\$204,221,800	-\$102,110,900	-\$126,324,420	-\$63,162,210
	<b>WAIVER--MH/UCD &amp; BTR SUBTOTAL</b>	<b>\$10,470,605,010</b>	<b>\$3,160,528,510</b>	<b>\$4,930,875,200</b>	<b>\$1,116,585,100</b>	<b>-\$5,539,729,810</b>	<b>-\$2,043,943,410</b>
<b><u>MANAGED CARE</u></b>							

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		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>MANAGED CARE</b>							
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	\$783,819,000	\$345,594,000	\$1,252,660,000	\$516,786,500	\$468,841,000	\$171,192,500
118	MANAGED CARE RATE RANGE IGTS	\$744,394,000	\$355,300,000	\$820,130,000	\$391,449,000	\$75,736,000	\$36,149,000
119	TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAY	\$125,278,000	\$61,273,500	\$5,706,904,000	\$2,804,982,500	\$5,581,626,000	\$2,743,709,000
120	MANAGED CARE PUBLIC HOSPITAL IGTS	\$443,548,000	\$221,774,000	\$399,710,000	\$199,855,000	-\$43,838,000	-\$21,919,000
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	\$383,441,000	\$191,720,500	\$0	\$0	-\$383,441,000	-\$191,720,500
123	TRANSFER OF IHSS COSTS TO CDSS	\$45,505,000	\$45,505,000	\$1,615,660,000	\$1,615,660,000	\$1,570,155,000	\$1,570,155,000
124	RETRO MC RATE ADJUSTMENTS	\$338,810,000	\$169,405,000	\$0	\$0	-\$338,810,000	-\$169,405,000
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	\$21,097,000	\$10,548,500	-\$16,426,000	-\$8,213,000	-\$37,523,000	-\$18,761,500
128	INCREASE IN CAPITATION RATES FOR GROSS PREMIL	\$8,862,000	\$4,358,000	\$0	\$0	-\$8,862,000	-\$4,358,000
131	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$0	\$0
132	CAPITATED RATE ADJUSTMENT FOR FY 2014-15	\$0	\$0	\$465,411,000	\$231,818,200	\$465,411,000	\$231,818,200
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO C	\$0	\$0	\$0	\$0	\$0	\$0
134	EXTEND GROSS PREMIUM TAX	\$0	\$0	\$0	\$0	\$0	\$0
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE	\$0	\$0	\$0	\$0	\$0	\$0
136	GENERAL FUND REIMBURSEMENTS FROM DPHS	\$0	\$0	\$0	\$0	\$0	\$0
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMEN	\$0	\$0	\$0	\$0	\$0	\$0
138	FFS COSTS FOR MANAGED CARE ENROLLEES	\$0	\$0	\$0	\$0	\$0	\$0
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	\$0	\$0	\$0	\$0	\$0	\$0
140	MCO TAX MANAGED CARE PLANS	\$0	\$0	\$0	\$0	\$0	\$0
141	SCAN TRANSITION TO MANAGED CARE	\$0	\$0	\$0	\$0	\$0	\$0
142	DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM	-\$1,100,000	-\$550,000	\$0	\$0	\$1,100,000	\$550,000
143	TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE	-\$140,711,000	-\$70,355,500	-\$3,788,843,000	-\$1,894,421,500	-\$3,648,132,000	-\$1,824,066,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$2,754,943,000</b>	<b>\$1,336,573,000</b>	<b>\$6,457,206,000</b>	<b>\$3,859,916,700</b>	<b>\$3,702,263,000</b>	<b>\$2,523,343,700</b>
<b>PROVIDER RATES</b>							
24	AB 1629 ADD-ONS	\$19,207,540	\$9,603,770	\$17,026,790	\$8,513,400	-\$2,180,750	-\$1,090,380

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

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>PROVIDER RATES</u></b>							
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	\$273,342,660	\$136,671,330	\$205,639,750	\$102,819,870	-\$67,702,910	-\$33,851,450
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	\$68,001,180	\$34,000,590	\$187,060,400	\$93,530,200	\$119,059,230	\$59,529,610
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYM	\$40,673,000	\$20,336,500	\$42,657,000	\$21,328,500	\$1,984,000	\$992,000
147	AIR AMBULANCE MEDICAL TRANSPORTATION	\$18,459,860	\$9,229,930	\$14,611,970	\$7,306,880	-\$3,847,880	-\$1,923,050
148	LTC RATE ADJUSTMENT	\$17,484,220	\$8,742,110	\$98,236,580	\$49,118,290	\$80,752,370	\$40,376,180
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	\$60,321,980	\$30,160,990	\$14,425,830	\$7,212,910	-\$45,896,150	-\$22,948,070
150	HOSPICE RATE INCREASES	\$4,416,510	\$2,208,250	\$11,180,100	\$5,590,050	\$6,763,600	\$3,381,800
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	\$0	\$0	\$0	\$0	\$0	\$0
152	NON-AB 1629 LTC RATE FREEZE	-\$1,872,000	-\$936,000	-\$35,022,000	-\$17,511,000	-\$33,150,000	-\$16,575,000
153	DENTAL RETROACTIVE RATE CHANGES	-\$4,782,000	-\$2,391,000	\$0	\$0	\$4,782,000	\$2,391,000
154	LABORATORY RATE METHODOLOGY CHANGE	-\$8,477,900	-\$4,238,950	-\$14,715,900	-\$7,357,950	-\$6,238,010	-\$3,119,000
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-\$13,035,000	-\$6,517,500	-\$34,256,000	-\$17,128,000	-\$21,221,000	-\$10,610,500
156	REDUCTION TO RADIOLOGY RATES	-\$28,638,160	-\$14,319,080	-\$60,399,470	-\$30,199,740	-\$31,761,310	-\$15,880,660
157	10% PROVIDER PAYMENT REDUCTION	-\$312,677,000	-\$156,338,500	-\$531,384,000	-\$265,692,000	-\$218,707,000	-\$109,353,500
	<b>PROVIDER RATES SUBTOTAL</b>	<b>\$132,424,880</b>	<b>\$66,212,440</b>	<b>-\$84,938,940</b>	<b>-\$42,468,580</b>	<b>-\$217,363,820</b>	<b>-\$108,681,020</b>
<b><u>SUPPLEMENTAL PMNTS.</u></b>							
158	HOSPITAL QAF - HOSPITAL PAYMENTS	\$4,209,680,000	\$2,114,955,000	\$0	\$0	-\$4,209,680,000	-\$2,114,955,000
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	\$2,261,177,000	\$1,137,338,000	\$7,024,244,000	\$3,539,684,000	\$4,763,067,000	\$2,402,346,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	\$455,989,000	\$0	\$66,000,000	\$0	-\$389,989,000	\$0
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	\$190,500,000	\$0	\$50,000,000	\$0	-\$140,500,000	\$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT	\$179,174,000	\$0	\$186,774,000	\$0	\$7,600,000	\$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	\$140,000,000	\$70,000,000	\$70,000,000	\$35,000,000	-\$70,000,000	-\$35,000,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	\$117,889,000	\$0	\$43,658,000	\$0	-\$74,231,000	\$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	\$117,187,000	\$48,689,500	\$110,857,000	\$45,211,000	-\$6,330,000	-\$3,478,500
166	FFP FOR LOCAL TRAUMA CENTERS	\$100,000,000	\$50,000,000	\$70,000,000	\$35,000,000	-\$30,000,000	-\$15,000,000

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

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b><u>SUPPLEMENTAL PMNTS.</u></b>							
167	IGT PAYMENTS FOR HOSPITAL SERVICES	\$15,000,000	\$7,500,000	\$15,000,000	\$7,500,000	\$0	\$0
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	\$10,000,000	\$5,000,000	\$10,000,000	\$5,000,000	\$0	\$0
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	\$8,000,000	\$4,000,000	\$8,000,000	\$4,000,000	\$0	\$0
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENT:	\$5,475,000	\$0	\$3,800,000	\$0	-\$1,675,000	\$0
	<b>SUPPLEMENTAL PMNTS. SUBTOTAL</b>	<b>\$7,810,071,000</b>	<b>\$3,437,482,500</b>	<b>\$7,658,333,000</b>	<b>\$3,671,395,000</b>	<b>-\$151,738,000</b>	<b>\$233,912,500</b>
<b><u>OTHER DEPARTMENTS</u></b>							
208	DENTAL CHILDREN'S OUTREACH AGES 0-3	\$0	\$0	\$17,467,000	\$8,098,000	\$17,467,000	\$8,098,000
	<b>SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$17,467,000</b>	<b>\$8,098,000</b>	<b>\$17,467,000</b>	<b>\$8,098,000</b>
<b><u>OTHER</u></b>							
177	ARRA HITECH - PROVIDER PAYMENTS	\$240,434,000	\$0	\$151,719,000	\$0	-\$88,715,000	\$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CD	\$133,245,000	\$0	\$88,060,000	\$0	-\$45,185,000	\$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMENT:	\$11,487,000	\$5,743,500	\$8,501,000	\$4,250,500	-\$2,986,000	-\$1,493,000
184	CDDS DENTAL SERVICES	\$11,430,000	\$11,430,000	\$11,430,000	\$11,430,000	\$0	\$0
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	\$20,565,000	\$8,740,000	\$16,415,000	\$6,481,000	-\$4,150,000	-\$2,259,000
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	\$7,837,000	\$2,351,000	\$0	\$0	-\$7,837,000	-\$2,351,000
187	AUDIT SETTLEMENTS	\$8,247,000	\$8,247,000	\$627,000	\$627,000	-\$7,620,000	-\$7,620,000
191	INDIAN HEALTH SERVICES	\$1,254,000	-\$9,435,500	\$2,180,000	-\$9,435,500	\$926,000	\$0
192	CIGARETTE AND TOBACCO SURTAX FUNDS	\$0	\$0	\$0	\$0	\$0	\$0
193	ANTI-FRAUD ACTIVITIES	-\$15,000,000	-\$7,500,000	-\$15,000,000	-\$7,500,000	\$0	\$0
194	CLPP FUND	\$0	\$0	\$0	\$0	\$0	\$0
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0	\$0	\$0	\$0
196	AB 97 INJUNCTIONS	\$0	\$0	\$0	\$0	\$0	\$0
197	TRANSFER OF IHSS COSTS TO DHCS	\$0	\$0	\$0	\$0	\$0	\$0
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	\$0	\$0	\$0	\$0	\$0	\$0
199	RECOVERY OF PCS/IHSS	\$0	\$0	-\$389,000	-\$194,500	-\$389,000	-\$194,500

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

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>OTHER</b>						
200	MEDICARE BUY-IN QUALITY REVIEW PROJECT	-\$4,000,000	-\$3,800,000	-\$2,400,000	-\$2,280,000	\$1,600,000	\$1,520,000
201	IHSS REDUCTION IN SERVICE HOURS	-\$196,331,000	\$0	-\$190,614,000	\$0	\$5,717,000	\$0
	<b>OTHER SUBTOTAL</b>	<b>\$219,168,000</b>	<b>\$15,776,000</b>	<b>\$70,529,000</b>	<b>\$3,378,500</b>	<b>-\$148,639,000</b>	<b>-\$12,397,500</b>
	<b>GRAND TOTAL</b>	<b>\$27,029,184,570</b>	<b>\$7,702,199,960</b>	<b>\$29,662,329,040</b>	<b>\$8,971,432,880</b>	<b>\$2,633,144,480</b>	<b>\$1,269,232,920</b>

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

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>PA-OAS</b>	<b>PA-AB</b>	<b>PA-ATD</b>	<b>PA-AFDC</b>	<b>LT-OAS</b>	<b>LT-AB</b>
PHYSICIANS	\$21,188,360	\$2,410,590	\$108,274,340	\$57,699,630	\$3,200,970	\$63,140
OTHER MEDICAL	\$50,337,690	\$7,316,140	\$286,093,220	\$336,418,790	\$7,420,530	\$264,860
COUNTY OUTPATIENT	\$410,780	\$105,170	\$6,750,720	\$1,771,230	\$182,620	\$20
COMMUNITY OUTPATIENT	\$7,717,910	\$1,324,100	\$89,660,040	\$31,251,340	\$478,450	\$12,240
PHARMACY	-\$2,813,510	-\$637,690	-\$46,912,630	\$52,460,690	-\$1,063,910	-\$16,250
COUNTY INPATIENT	\$6,718,920	\$724,600	\$59,741,870	\$25,141,560	\$2,287,830	\$2,790
COMMUNITY INPATIENT	\$92,248,250	\$9,478,780	\$577,529,220	\$260,109,140	\$16,537,420	\$780,660
NURSING FACILITIES	\$349,805,630	\$14,913,900	\$530,457,750	\$2,297,000	\$1,434,180,000	\$5,682,700
ICF-DD	\$425,440	\$5,339,090	\$112,855,280	\$427,740	\$16,272,300	\$1,659,760
MEDICAL TRANSPORTATION	\$13,082,170	\$2,740,820	\$36,935,470	\$5,103,450	\$4,003,630	\$72,570
OTHER SERVICES	\$28,715,970	\$3,145,900	\$87,006,540	\$40,992,020	\$51,345,480	\$143,000
HOME HEALTH	\$260,320	\$9,092,910	\$101,065,670	\$4,056,960	\$3,470	\$0
<b>FFS SUBTOTAL</b>	<b>\$568,097,930</b>	<b>\$55,954,310</b>	<b>\$1,949,457,480</b>	<b>\$817,729,540</b>	<b>\$1,534,848,800</b>	<b>\$8,665,490</b>
DENTAL	\$39,098,180	\$1,970,790	\$93,667,980	\$128,970,640	\$2,594,840	\$12,630
TWO PLAN MODEL	\$780,968,880	\$128,754,560	\$8,061,790,330	\$2,242,764,220	-\$78,040	-\$78,040
COUNTY ORGANIZED HEALTH SYSTEMS	\$366,035,860	\$30,447,430	\$1,460,737,200	\$394,655,170	\$853,056,580	\$3,136,130
GEOGRAPHIC MANAGED CARE	\$99,624,120	\$17,645,680	\$1,118,317,860	\$282,810,420	-\$5,080	-\$5,080
PHP & OTHER MANAG. CARE	\$252,852,130	\$6,097,310	\$150,744,590	\$20,165,110	\$14,943,380	\$9,210
EPSDT SCREENS	\$0	\$0	\$0	\$9,321,890	\$0	\$0
MEDICARE PAYMENTS	\$1,416,023,210	\$43,130,170	\$1,338,085,620	\$0	\$159,255,180	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$94,730	\$1,535,740	\$58,551,540	\$566,670	\$13,915,310	\$1,056,760
MISC. SERVICES	\$642,876,320	\$34,087,180	\$3,200,385,060	\$980,260	\$1,230,520	\$20
<b>NON-FFS SUBTOTAL</b>	<b>\$3,597,573,420</b>	<b>\$263,668,880</b>	<b>\$15,482,280,170</b>	<b>\$3,080,234,390</b>	<b>\$1,044,912,690</b>	<b>\$4,131,630</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$4,165,671,350</b>	<b>\$319,623,200</b>	<b>\$17,431,737,650</b>	<b>\$3,897,963,930</b>	<b>\$2,579,761,500</b>	<b>\$12,797,120</b>
<b>ELIGIBLES ***</b>	<b>424,800</b>	<b>23,000</b>	<b>1,092,600</b>	<b>1,498,100</b>	<b>46,300</b>	<b>200</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$9,806</b>	<b>\$13,897</b>	<b>\$15,954</b>	<b>\$2,602</b>	<b>\$55,718</b>	<b>\$63,986</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$817</b>	<b>\$1,158</b>	<b>\$1,330</b>	<b>\$217</b>	<b>\$4,643</b>	<b>\$5,332</b>

(1) Does not include Audits & Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

Excluded policy changes: 73. Refer to page following report for listing.

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>LT-ATD</b>	<b>MN-OAS</b>	<b>MN-AB</b>	<b>MN-ATD</b>	<b>MN-AFDC</b>	<b>MI-C</b>
PHYSICIANS	\$5,122,230	\$17,307,650	\$218,260	\$41,786,130	\$281,382,310	\$49,900,800
OTHER MEDICAL	\$5,778,640	\$53,241,130	\$653,360	\$84,925,960	\$918,334,080	\$211,922,510
COUNTY OUTPATIENT	\$380,720	\$1,382,260	\$24,240	\$7,127,650	\$20,804,610	\$2,788,210
COMMUNITY OUTPATIENT	\$852,710	\$5,414,220	\$118,430	\$21,703,910	\$127,266,860	\$24,069,580
PHARMACY	-\$1,895,430	-\$2,182,380	\$2,610	\$231,040	\$94,321,830	\$90,838,070
COUNTY INPATIENT	\$16,245,070	\$18,449,780	\$484,480	\$147,137,050	\$229,349,760	\$27,251,580
COMMUNITY INPATIENT	\$27,291,430	\$50,564,670	\$1,548,540	\$323,966,320	\$1,177,352,440	\$188,283,410
NURSING FACILITIES	\$426,678,040	\$173,035,870	\$407,620	\$58,447,280	\$18,000,950	\$9,413,510
ICF-DD	\$89,391,120	\$547,690	\$0	\$5,964,090	\$335,170	\$1,843,860
MEDICAL TRANSPORTATION	\$2,164,890	\$10,862,180	\$169,770	\$16,524,220	\$16,880,510	\$3,677,680
OTHER SERVICES	\$10,187,680	\$13,952,570	\$51,290	\$22,408,690	\$97,433,400	\$31,073,420
HOME HEALTH	\$16,870	\$353,310	\$62,560	\$42,998,380	\$11,360,770	\$20,934,510
<b>FFS SUBTOTAL</b>	<b>\$582,213,980</b>	<b>\$342,928,950</b>	<b>\$3,741,160</b>	<b>\$773,220,710</b>	<b>\$2,992,822,680</b>	<b>\$661,997,140</b>
DENTAL	\$832,140	\$29,264,680	\$58,020	\$18,106,360	\$345,823,260	\$77,145,150
TWO PLAN MODEL	-\$78,040	\$1,282,977,540	\$5,087,050	\$908,258,660	\$556,403,440	\$244,607,240
COUNTY ORGANIZED HEALTH SYSTEMS	\$323,243,440	\$314,532,260	\$752,440	\$390,453,850	\$1,262,823,900	\$135,293,900
GEOGRAPHIC MANAGED CARE	-\$5,080	\$108,973,160	\$121,040	\$87,989,150	\$507,571,760	\$26,290,110
PHP & OTHER MANAG. CARE	\$629,260	\$198,552,820	\$21,374,730	\$2,834,380	\$50,796,050	\$3,586,990
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$23,632,700	\$1,558,800
MEDICARE PAYMENTS	\$39,646,170	\$721,105,440	\$0	\$367,305,160	\$70,655,030	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$185,808,900	\$31,220	\$28,210	\$239,360	\$143,240	\$460,900
MISC. SERVICES	\$1,384,570	\$472,245,410	\$925,450	\$575,963,470	\$2,385,380	\$6,477,550
<b>NON-FFS SUBTOTAL</b>	<b>\$551,461,350</b>	<b>\$3,127,682,530</b>	<b>\$28,346,930</b>	<b>\$2,351,150,380</b>	<b>\$2,820,234,760</b>	<b>\$495,420,640</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$1,133,675,330</b>	<b>\$3,470,611,480</b>	<b>\$32,088,090</b>	<b>\$3,124,371,090</b>	<b>\$5,813,057,440</b>	<b>\$1,157,417,790</b>
<b>ELIGIBLES ***</b>	<b>14,800</b>	<b>324,100</b>	<b>600</b>	<b>203,300</b>	<b>3,809,400</b>	<b>811,600</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$76,600</b>	<b>\$10,708</b>	<b>\$53,480</b>	<b>\$15,368</b>	<b>\$1,526</b>	<b>\$1,426</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$6,383</b>	<b>\$892</b>	<b>\$4,457</b>	<b>\$1,281</b>	<b>\$127</b>	<b>\$119</b>

(1) Does not include Audits &amp; Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

Excluded policy changes: 73. Refer to page following report for listing.

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<b>SERVICE CATEGORY</b>	<b>MI-A</b>	<b>REFUGEE</b>	<b>OBRA</b>	<b>POV 185</b>	<b>POV 133</b>	<b>POV 100</b>
PHYSICIANS	\$98,049,650	\$331,900	\$18,456,290	\$199,059,370	\$7,763,890	\$5,379,090
OTHER MEDICAL	\$463,551,750	\$1,934,250	\$40,627,900	\$237,071,650	\$83,677,400	\$33,930,820
COUNTY OUTPATIENT	\$7,934,110	\$175,800	\$4,435,020	\$3,643,710	\$307,420	\$360,530
COMMUNITY OUTPATIENT	\$21,055,440	\$113,780	\$5,341,500	\$30,031,940	\$5,068,140	\$4,880,970
PHARMACY	\$235,003,170	\$450,980	\$10,627,460	\$7,674,580	\$5,523,560	\$7,586,750
COUNTY INPATIENT	\$43,843,280	\$53,810	\$63,445,420	\$64,095,400	\$1,229,860	\$2,408,800
COMMUNITY INPATIENT	\$281,608,870	\$467,100	\$85,133,670	\$462,946,760	\$20,301,750	\$21,662,270
NURSING FACILITIES	\$35,529,630	\$2,370	\$20,965,870	\$398,000	\$644,190	\$661,940
ICF-DD	\$619,800	\$0	\$214,440	\$0	\$0	\$3,340
MEDICAL TRANSPORTATION	\$11,457,620	\$10,880	\$4,203,230	\$1,919,520	\$454,870	\$270,770
OTHER SERVICES	\$21,366,530	\$12,420	\$1,625,240	\$12,483,670	\$12,682,940	\$5,797,360
HOME HEALTH	\$159,520	\$140	\$17,030	\$2,106,520	\$2,507,560	\$1,350,790
<b>FFS SUBTOTAL</b>	<b>\$1,220,179,360</b>	<b>\$3,553,430</b>	<b>\$255,093,060</b>	<b>\$1,021,431,130</b>	<b>\$140,161,590</b>	<b>\$84,293,440</b>
DENTAL	\$14,248,820	\$80,720	\$175,940	\$1,418,690	\$102,773,320	\$24,540,170
TWO PLAN MODEL	\$3,295,456,980	\$1,959,930	\$0	\$105,405,200	\$619,619,910	\$309,618,950
COUNTY ORGANIZED HEALTH SYSTEMS	\$1,413,130,670	\$280,650	\$3,976,420	\$35,611,510	\$250,949,250	\$88,299,200
GEOGRAPHIC MANAGED CARE	\$522,866,280	\$592,850	\$0	\$14,631,340	\$109,623,700	\$56,134,390
PHP & OTHER MANAG. CARE	\$26,970	\$0	\$0	\$2,226,170	\$2,232,900	\$2,660,910
EPSDT SCREENS	\$0	\$0	\$0	\$0	\$1,119,400	\$1,333,960
MEDICARE PAYMENTS	\$0	\$0	\$0	\$0	\$0	\$0
STATE HOSP./DEVELOPMENTAL CNTRS.	\$17,660	\$0	\$230,580	\$86,410	\$0	\$261,150
MISC. SERVICES	\$50,054,970	\$0	\$0	\$242,290	\$180,300	\$62,110
<b>NON-FFS SUBTOTAL</b>	<b>\$5,295,802,340</b>	<b>\$2,914,140</b>	<b>\$4,382,930</b>	<b>\$159,621,610</b>	<b>\$1,086,498,760</b>	<b>\$482,910,850</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$6,515,981,700</b>	<b>\$6,467,570</b>	<b>\$259,476,000</b>	<b>\$1,181,052,730</b>	<b>\$1,226,660,350</b>	<b>\$567,204,280</b>
<b>ELIGIBLES ***</b>	<b>774,000</b>	<b>2,600</b>	<b>61,100</b>	<b>207,600</b>	<b>600,000</b>	<b>212,100</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$8,419</b>	<b>\$2,488</b>	<b>\$4,247</b>	<b>\$5,689</b>	<b>\$2,044</b>	<b>\$2,674</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$702</b>	<b>\$207</b>	<b>\$354</b>	<b>\$474</b>	<b>\$170</b>	<b>\$223</b>

(1) Does not include Audits & Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

Excluded policy changes: 73. Refer to page following report for listing.

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

<u>SERVICE CATEGORY</u>	<u>TOTAL</u>
PHYSICIANS	\$917,594,590
OTHER MEDICAL	\$2,823,500,680
COUNTY OUTPATIENT	\$58,584,820
COMMUNITY OUTPATIENT	\$376,361,560
PHARMACY	\$449,198,940
COUNTY INPATIENT	\$708,611,850
COMMUNITY INPATIENT	\$3,597,810,730
NURSING FACILITIES	\$3,081,522,230
ICF-DD	\$235,899,110
MEDICAL TRANSPORTATION	\$130,534,280
OTHER SERVICES	\$440,424,110
HOME HEALTH	\$196,347,290
<b>FFS SUBTOTAL</b>	<b>\$13,016,390,190</b>
DENTAL	\$880,782,320
TWO PLAN MODEL	\$18,543,438,750
COUNTY ORGANIZED HEALTH SYSTEMS	\$7,327,415,860
GEOGRAPHIC MANAGED CARE	\$2,953,176,620
PHP & OTHER MANAG. CARE	\$729,732,900
EPSDT SCREENS	\$36,966,750
MEDICARE PAYMENTS	\$4,155,206,000
STATE HOSP./DEVELOPMENTAL CNTRS.	\$263,028,360
MISC. SERVICES	\$4,989,480,850
<b>NON-FFS SUBTOTAL</b>	<b>\$39,879,228,410</b>
<b>TOTAL DOLLARS (1)</b>	<b>\$52,895,618,600</b>
<b>ELIGIBLES ***</b>	<b>10,106,200</b>
<b>ANNUAL \$/ELIGIBLE</b>	<b>\$5,234</b>
<b>AVG. MO. \$/ELIGIBLE</b>	<b>\$436</b>

(1) Does not include Audits & Lawsuits, Recoveries, and Mental Health Services.

\*\*\* Eligibles include the estimated impact of eligibility policy changes.

Excluded policy changes: 73. Refer to page following report for listing.

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

EXCLUDED POLICY CHANGES: 73

2	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
6	CHDP GATEWAY - PREENROLLMENT
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION
49	SCHIP FUNDING FOR PRENATAL CARE
51	WOMEN'S HEALTH SERVICES
57	FAMILY PACT DRUG REBATES
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
84	BTR - LIHP - MCE
85	MH/UCD & BTR—DSH PAYMENT
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
88	BTR—SAFETY NET CARE POOL
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
90	BTR—LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—CCS AND GHPP
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
95	BTR—DESIGNATED STATE HEALTH PROGRAMS
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES
98	BTR—INCREASE SAFETY NET CARE POOL
99	MH/UCD—STABILIZATION FUNDING
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

104	MH/UCD—SAFETY NET CARE POOL
105	MH/UCD & BTR—MIA-LTC
106	MH/UCD & BTR—BCCTP
107	MH/UCD & BTR—DPH INTERIM RATE
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
109	HOSPITAL STABILIZATION
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
111	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS
123	TRANSFER OF IHSS COSTS TO CDSS
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF
134	EXTEND GROSS PREMIUM TAX
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE
136	GENERAL FUND REIMBURSEMENTS FROM DPHS
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
153	DENTAL RETROACTIVE RATE CHANGES
158	HOSPITAL QAF - HOSPITAL PAYMENTS
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT
163	NDPH IGT SUPPLEMENTAL PAYMENTS
164	CERTIFICATION PAYMENTS FOR DP-NFS
165	CAPITAL PROJECT DEBT REIMBURSEMENT
166	FFP FOR LOCAL TRAUMA CENTERS
167	IGT PAYMENTS FOR HOSPITAL SERVICES
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
177	ARRA HITECH - PROVIDER PAYMENTS

**FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON NOVEMBER 2013 ESTIMATE**

180	MEDI-CAL TCM PROGRAM
184	CDDS DENTAL SERVICES
187	AUDIT SETTLEMENTS
192	CIGARETTE AND TOBACCO SURTAX FUNDS
194	CLPP FUND
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE
197	TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
212	AIM LINKED MOTHERS 200-300% FPL

**Estimated Average Monthly Certified Eligibles  
November 2013 Estimate  
Fiscal Years 2012-2013, 2013-2014 & 2014-2015**

***(With Estimated Impact of Eligibility Policy Changes)\*\*\****

	2012-2013	2013-2014	2014-2015	12-13 To 13-14 % Change	13-14 To 14-15 % Change
<b>Public Assistance</b>	<b>2,836,400</b>	<b>2,877,100</b>	<b>3,038,500</b>	<b>1.43%</b>	<b>5.61%</b>
Aged	412,400	419,500	424,800	1.72%	1.26%
Blind	21,500	21,800	23,000	1.40%	5.50%
Disabled	985,100	1,019,400	1,092,600	3.48%	7.18%
Families	1,417,400	1,416,400	1,498,100	-0.07%	5.77%
<b>Long Term</b>	<b>61,700</b>	<b>61,200</b>	<b>61,300</b>	<b>-0.81%</b>	<b>0.16%</b>
Aged	46,600	46,200	46,300	-0.86%	0.22%
Blind	200	200	200	0.00%	0.00%
Disabled	14,900	14,800	14,800	-0.67%	0.00%
<b>Medically Needy <sup>1</sup></b>	<b>3,954,700</b>	<b>4,072,900</b>	<b>4,327,200</b>	<b>2.99%</b>	<b>6.24%</b>
Aged	293,000	306,000	318,000	4.44%	3.92%
Blind	600	600	600	0.00%	0.00%
Disabled	170,200	180,500	199,200	6.05%	10.36%
Families <sup>2</sup>	3,490,900	3,585,800	3,809,400	2.72%	6.24%
<b>Medically Indigent</b>	<b>351,000</b>	<b>1,118,200</b>	<b>1,585,600</b>	<b>218.58%</b>	<b>41.80%</b>
Children	349,100	788,400	811,600	125.84%	2.94%
Adults	1,900	329,800	774,000	17257.89%	134.69%
<b>Other</b>	<b>685,600</b>	<b>1,041,100</b>	<b>1,093,600</b>	<b>51.85%</b>	<b>5.04%</b>
Refugees	2,400	2,400	2,600	0.00%	8.33%
Undocumented Persons <sup>3</sup>	61,700	61,100	61,100	-0.97%	0.00%
185% Poverty <sup>4</sup>	180,700	194,000	207,600	7.36%	7.01%
133% Poverty	253,800	574,200	600,000	126.24%	4.49%
100% Poverty	177,400	199,200	212,100	12.29%	6.48%
QMB	9,600	10,200	10,200	6.25%	0.00%
<b>GRAND TOTAL <sup>5</sup></b>	<b>7,889,400</b>	<b>9,170,500</b>	<b>10,106,200</b>	<b>16.24%</b>	<b>10.20%</b>

**Note:** Graphs of eligibles represent base projections only and do not reflect estimated impact of policy changes.

\*\*\* See CL Page B reflecting impact of Policy Changes.

<sup>1</sup> Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

<sup>2</sup> The 1931(b) category of eligibility is included in MN-Families and PA-Families.

<sup>3</sup> Undocumented Persons include aid codes 55, 58, 5F, C1-C9, & D1-D9. Aid codes 55, 58, & 5F include the Medically Needy & Medically Indigent; however, the program cannot be determined by these aid codes. All other undocumented persons are included in the Medi-Cal program for which they are eligible. Total undocumented persons included above are:

	<u>2012-2013</u>	<u>2013-2014</u>	<u>2014-2015</u>
Total Undoc. Persons	811,400	817,100	823,500

<sup>4</sup> Includes the following presumptive eligibility for pregnant women program eligibles:

	<u>2012-2013</u>	<u>2013-2014</u>	<u>2014-2015</u>
Presumptive Eligibility	28,300	29,600	29,600

<sup>5</sup> The following Medi-Cal special program eligibles (average monthly during FY 2011-12 shown in parenthesis) are not included above: BCCTP (12,604), Tuberculosis (834), Dialysis (137), TPN (3), QDWI (0), SLMB (5,353), and QI-1 (15,043). Family PACT eligibles are also not included above.

**November 2013 Medi-Cal Estimate  
Caseload Changes Identified in Policy Changes  
(Portion not in the base estimate)**

<u>Policy Change</u>	<u>Budget Aid Category</u>	<u>Caseload Change</u> <u>Average Monthly Eligibles</u> <u>not in the Base Estimate</u>		
		<u>2012-13</u>	<u>2013-14</u>	<u>2014-15</u>
PC 1 Transition of HFP to Medi-Cal	MI-C	132,805	562,536	573,663
	133% Poverty	95,965	406,489	421,197
	<b>Total</b>	<b>228,770</b>	<b>969,026</b>	<b>994,860</b>
PC 5 Medi-Cal Adult Inmate Programs	LT-OAS	2	10	10
	MN-OAS	118	81	81
	MN-ATD	20	14	14
	MI-C	9	6	6
	POV 185	13	7	7
	<b>Total</b>	<b>160</b>	<b>118</b>	<b>118</b>
PC 7 Medi-Cal Inpt Hosp Costs - Juvenile Inmates	MI-C	59	128	128
	<b>Total</b>	<b>59</b>	<b>128</b>	<b>128</b>
PC 23 ACA Exp-Adult Inmates Inpt. Hosp. Costs	MI-A	0	428	428
	<b>Total</b>	<b>0</b>	<b>428</b>	<b>428</b>
PC 16 PARIS-Veterans	LTC-OAS	(1)	(3)	(3)
	MN-OAS		(1)	(1)
	MN-ATD		(2)	(2)
	MN-AFDC	(2)	(1)	(1)
	<b>Total</b>	<b>(3)</b>	<b>(8)</b>	<b>(8)</b>
PC 17 PARIS-Interstate	PA-OAS	0	(0)	(0)
	PA-ATD	0	(0)	(0)
	PA-AFDC	0	(10)	(10)
	MN-OAS	0	(8)	(8)
	MN-ATD	0	(4)	(4)
	MN-AFDC	0	(52)	(52)
	LTC-OAS	0	0	0
	MI-C	0	0	0
	<b>Total</b>	<b>0</b>	<b>(74)</b>	<b>(74)</b>
PC 15 PARIS-Federal	LT-ATD	0	(2)	(2)
	MN-OAS	0	(2)	(2)
	MN-ATD	0	(0)	(0)
	MN-AFDC	0	(5)	(5)
	MI-C	0	(0)	(0)
	<b>Total</b>	<b>0</b>	<b>(9)</b>	<b>(9)</b>
PC 14 Incarceration Verification Program	MN-AFDC	(5)	(5)	(6)
	PA-AFDC	(1)	(1)	(1)
	<b>Total</b>	<b>(6)</b>	<b>(6)</b>	<b>(6)</b>
PC 4 AIM Linked Infants 250-300% FPL	MI-C	0	3,997	3,997
	<b>Total</b>	<b>0</b>	<b>3,997</b>	<b>3,997</b>
PC 21 ACA Mandatory Expansion	PA-AB	0	408	1,597
	PA-ATD	0	18,907	73,935
	PA-AFDC	0	27,306	106,780
	MN-AB	0	11	43
	MN-ATD	0	3,346	13,084
	MN-AFDC	0	66,608	260,468
	MI-C	0	4,136	16,176
	MI-A	0	36	140
	POV 185	0	2,929	11,454
	POV 133	0	3,013	11,782
	POV 100	0	3,345	13,081
	<b>Total</b>	<b>0</b>	<b>130,046</b>	<b>508,540</b>

Notes: MN AFDC includes the 1931(b) Program.

(Continued)

Family PACT, Healthy Families (7X, 8X) and BCCTP eligibles are not included in caseload chart.

**November 2013 Medi-Cal Estimate  
Caseload Changes Identified in Policy Changes  
(Portion not in the base estimate)**

<u>Policy Change</u>	<u>Budget Aid Category</u>	<b>Caseload Change Average Monthly Eligibles not in the Base Estimate</b>		
		<u>2012-13</u>	<u>2013-14</u>	<u>2014-15</u>
<b>PC 18 ACA Optional Expansion</b>	MI-A	0	326,592	769,069
	<b>Total</b>	<b>0</b>	<b>326,592</b>	<b>769,069</b>
<b>PC 26 ACA Expansion-New Qualified Immigrants</b>	PA-OAS	0	163	527
	PA-AB	0	8	27
	PA-ATD	0	389	1,262
	PA-AFDC	0	562	1,822
	LT-OAS	0	18	59
	LT-AB	0	0	0
	LT-ATD	0	6	19
	MN-OAS	0	117	380
	MN-AB	0	0	1
	MN-ATD	0	69	223
	MN-AFDC	0	1,372	4,445
	MI-C	0	85	276
	MI-A	0	1	2
	POV 185	0	60	195
	POV 133	0	62	201
	POV 100	0	69	223
	<b>Total</b>	<b>0</b>	<b>2,982</b>	<b>9,665</b>
<b>PC 29 State-Only Former Foster Care</b>	MI-C	0	83	83
	<b>Total</b>	<b>0</b>	<b>83</b>	<b>83</b>
<b>PC 25 ACA Hospital Presumptive Eligibility</b>	PA-AB	0	7	22
	PA-ATD	0	345	1,014
	PA-AFDC	0	498	1,465
	MN-AB	0	0	1
	MN-ATD	0	61	179
	MN-AFDC	0	23,141	25,718
	MI-C	0	212	359
	MI-A	0	727	2,318
	POV 185	0	53	157
	POV 133	0	55	162
	POV 100	0	61	179
<b>Total</b>	<b>0</b>	<b>25,160</b>	<b>31,574</b>	
<b>Total by aid code group</b>	<b>By Aid Category Group</b>			
	PA Aged	0	162	527
	PA Blind	0	424	1,646
	PA Disabled	0	19,641	76,210
	PA AFDC (Families)	(1)	28,356	110,057
	LT Aged	1	26	67
	LT Blind	0	0	0
	LT Disabled	0	4	17
	MN Aged	118	187	449
	MN Blind	0	12	45
	MN Disabled	20	3,484	13,494
	MN AFDC (Families)	(7)	91,056	290,568
	MI Adult	0	327,784	771,958
	MI Children	132,873	571,184	594,687
	185% Poverty	13	3,050	11,813
	133% Poverty	95,965	409,619	433,342
	100% Poverty	0	3,475	13,484
	<b>Total</b>	<b>228,982</b>	<b>1,458,464</b>	<b>2,318,366</b>
	<b>Total Caseload PC Changes</b>	<b>228,982</b>	<b>1,458,464</b>	<b>2,318,366</b>

Notes: MN AFDC includes the 1931(b) Program.

Family PACT, Healthy Families (7X, 8X) and BCCTP eligibles are not included in caseload chart.

**Comparison of Average Monthly Certified Eligibles  
November 2013 Estimate  
Fiscal Year 2013-14**

*(With Estimated Impact of Eligibility Policy Changes)*

	Appropriation 2013-2014	November 2013 2013-2014	% Change
<b>Public Assistance</b>	<b>2,930,800</b>	<b>2,877,100</b>	<b>-1.83%</b>
Aged	416,900	419,500	0.62%
Blind	21,900	21,800	-0.46%
Disabled	1,021,800	1,019,400	-0.23%
Families	1,470,200	1,416,400	-3.66%
<b>Long Term</b>	<b>62,000</b>	<b>61,200</b>	<b>-1.29%</b>
Aged	46,800	46,200	-1.28%
Blind	200	200	0.00%
Disabled	15,000	14,800	-1.33%
<b>Medically Needy <sup>1</sup></b>	<b>4,066,400</b>	<b>4,072,900</b>	<b>0.16%</b>
Aged	304,400	306,000	0.53%
Blind	600	600	0.00%
Disabled	183,800	180,500	-1.80%
Families	3,577,600	3,585,800	0.23%
<b>Medically Indigent</b>	<b>1,009,100</b>	<b>1,118,200</b>	<b>10.81%</b>
Children	719,300	788,400	9.61%
Adults	289,800	329,800	13.80%
<b>Other</b>	<b>964,900</b>	<b>1,041,100</b>	<b>7.90%</b>
Refugees	2,500	2,400	-4.00%
Undocumented Persons	61,500	61,100	-0.65%
185% Poverty	185,100	194,000	4.81%
133% Poverty	525,100	574,200	9.35%
100% Poverty	180,900	199,200	10.12%
QMB	9,800	10,200	4.08%
<b>GRAND TOTAL</b>	<b>9,033,200</b>	<b>9,170,500</b>	<b>1.52%</b>

<sup>1</sup> Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

**Estimated Average Monthly Certified Eligibles**  
**November 2013 Estimate**  
**Fiscal Years 2012-2013, 2013-2014 & 2014-2015**

<b>Managed Care</b>					
<i>(With Estimated Impact of Eligibility Policy Changes)***</i>					
	2012-2013	2013-2014	2014-2015	12-13 To 13-14 % Change	13-14 To 14-15 % Change
<b>Public Assistance</b>	<b>1,929,680</b>	<b>1,994,410</b>	<b>2,161,380</b>	<b>3.35%</b>	<b>8.37%</b>
Aged	105,590	114,920	119,830	8.84%	4.27%
Blind	10,550	11,220	12,500	6.35%	11.41%
Disabled	597,860	639,430	717,000	6.95%	12.13%
Families	1,215,680	1,228,840	1,312,050	1.08%	6.77%
<b>Long Term</b>	<b>11,320</b>	<b>11,290</b>	<b>11,330</b>	<b>-0.27%</b>	<b>0.35%</b>
Aged	8,120	8,090	8,110	-0.37%	0.25%
Blind	30	30	30	0.00%	0.00%
Disabled	3,170	3,170	3,190	0.00%	0.63%
<b>Medically Needy <sup>1</sup></b>	<b>2,574,010</b>	<b>2,695,360</b>	<b>2,941,330</b>	<b>4.71%</b>	<b>9.13%</b>
Aged	127,590	135,790	142,360	6.43%	4.84%
Blind	290	310	350	6.90%	12.90%
Disabled	71,180	79,180	92,520	11.24%	16.85%
Families <sup>2</sup>	2,374,950	2,480,080	2,706,100	4.43%	9.11%
<b>Medically Indigent</b>	<b>186,970</b>	<b>952,180</b>	<b>1,418,610</b>	<b>409.27%</b>	<b>48.99%</b>
Children	186,520	625,060	648,910	235.12%	3.82%
Adults	450	327,120	769,700	72593.33%	135.30%
<b>Other</b>	<b>407,580</b>	<b>758,130</b>	<b>806,610</b>	<b>86.01%</b>	<b>6.39%</b>
Refugees	1,340	1,500	1,510	11.94%	0.67%
Undocumented Persons	520	510	510	-1.92%	0.00%
185% Poverty	49,890	55,400	64,830	11.04%	17.02%
133% Poverty	222,820	544,970	570,680	144.58%	4.72%
100% Poverty	133,010	155,750	169,080	17.10%	8.56%
<b>GRAND TOTAL <sup>3</sup></b>	<b>5,109,560</b>	<b>6,411,370</b>	<b>7,339,260</b>	<b>25.48%</b>	<b>14.47%</b>
Percent of Statewide	<b>64.76%</b>	<b>69.91%</b>	<b>72.62%</b>		

\*\*\* See Attached Chart reflecting impact of Policy Changes.

<sup>1</sup> Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

<sup>2</sup> The 1931(b) category of eligibility is included in MN-Families and PA-Families.

<sup>3</sup> Eligibles enrolled or estimated to be enrolled in a medical Managed Care plan.

**Estimated Average Monthly Certified Eligibles**  
**November 2013 Estimate**  
**Fiscal Years 2012-2013, 2013-2014 & 2014-2015**

<b>Fee-For-Service</b>					
<i>(With Estimated Impact of Eligibility Policy Changes)***</i>					
	2012-2013	2013-2014	2014-2015	12-13 To 13-14 % Change	13-14 To 14-15 % Change
<b>Public Assistance</b>	<b>906,720</b>	<b>882,690</b>	<b>877,120</b>	<b>-2.65%</b>	<b>-0.63%</b>
Aged	306,810	304,580	304,970	-0.73%	0.13%
Blind	10,950	10,580	10,500	-3.38%	-0.76%
Disabled	387,240	379,970	375,600	-1.88%	-1.15%
Families	201,720	187,560	186,050	-7.02%	-0.81%
<b>Long Term</b>	<b>50,380</b>	<b>49,910</b>	<b>49,970</b>	<b>-0.93%</b>	<b>0.12%</b>
Aged	38,480	38,110	38,190	-0.96%	0.21%
Blind	170	170	170	0.00%	0.00%
Disabled	11,730	11,630	11,610	-0.85%	-0.17%
<b>Medically Needy <sup>1</sup></b>	<b>1,380,690</b>	<b>1,377,540</b>	<b>1,385,870</b>	<b>-0.23%</b>	<b>0.60%</b>
Aged	165,410	170,210	175,640	2.90%	3.19%
Blind	310	290	250	-6.45%	-13.79%
Disabled	99,020	101,320	106,680	2.32%	5.29%
Families <sup>2</sup>	1,115,950	1,105,720	1,103,300	-0.92%	-0.22%
<b>Medically Indigent</b>	<b>164,030</b>	<b>166,020</b>	<b>166,990</b>	<b>1.21%</b>	<b>0.58%</b>
Children	162,580	163,340	162,690	0.47%	-0.40%
Adults	1,450	2,680	4,300	84.83%	60.45%
<b>Other</b>	<b>278,020</b>	<b>282,970</b>	<b>286,990</b>	<b>1.78%</b>	<b>1.42%</b>
Refugees	1,060	900	1,090	-15.09%	21.11%
Undocumented Persons	61,180	60,590	60,590	-0.96%	0.00%
185% Poverty	130,810	138,600	142,770	5.96%	3.01%
133% Poverty	30,980	29,230	29,320	-5.65%	0.31%
100% Poverty	44,390	43,450	43,020	-2.12%	-0.99%
<b>GRAND TOTAL</b>	<b>2,779,840</b>	<b>2,759,130</b>	<b>2,766,940</b>	<b>-0.75%</b>	<b>0.28%</b>
<b>Percent of Statewide</b>	<b>35.24%</b>	<b>30.09%</b>	<b>27.38%</b>		

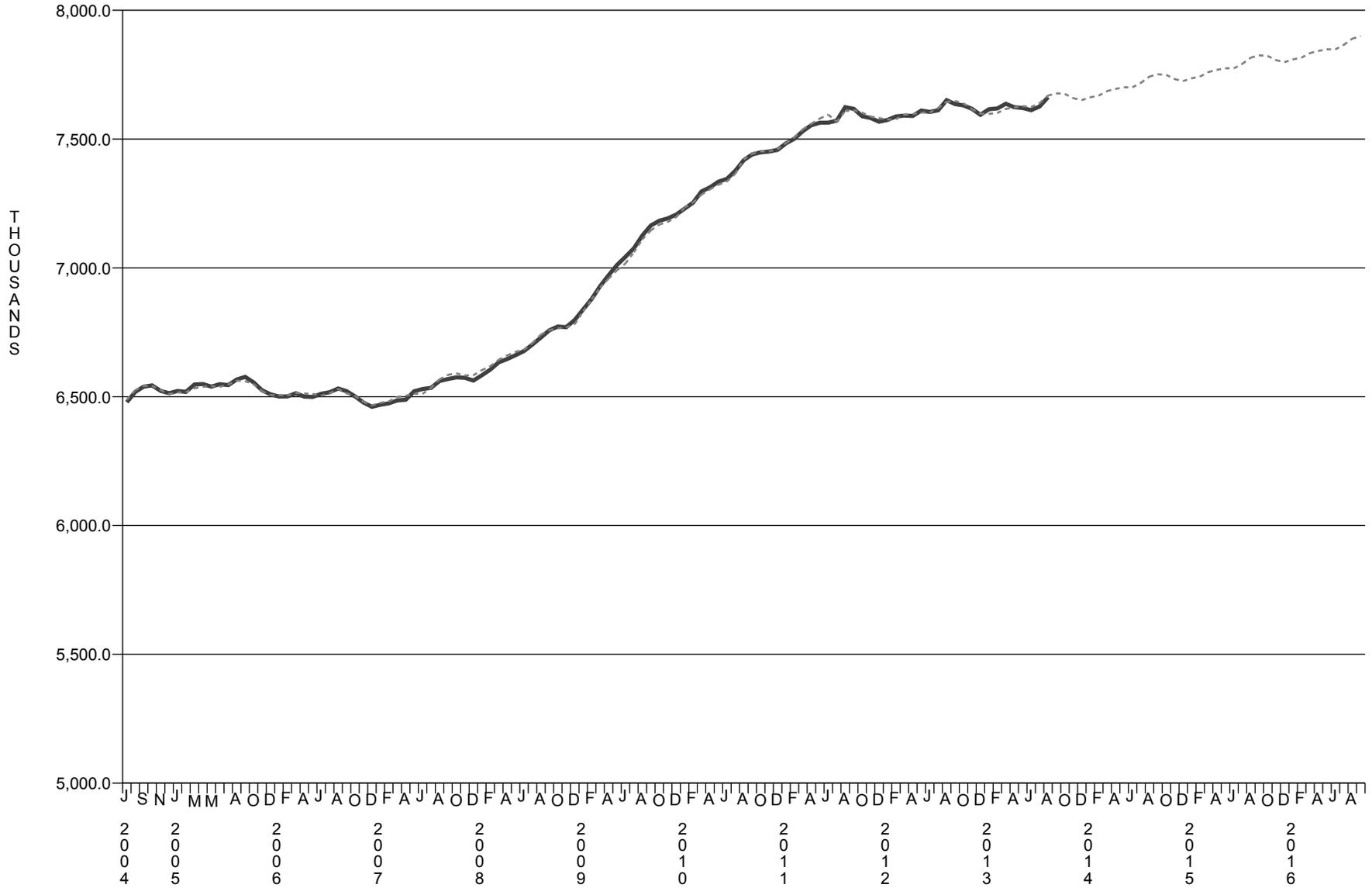
\*\*\* See Attached Chart reflecting impact of Policy Changes.

<sup>1</sup> Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

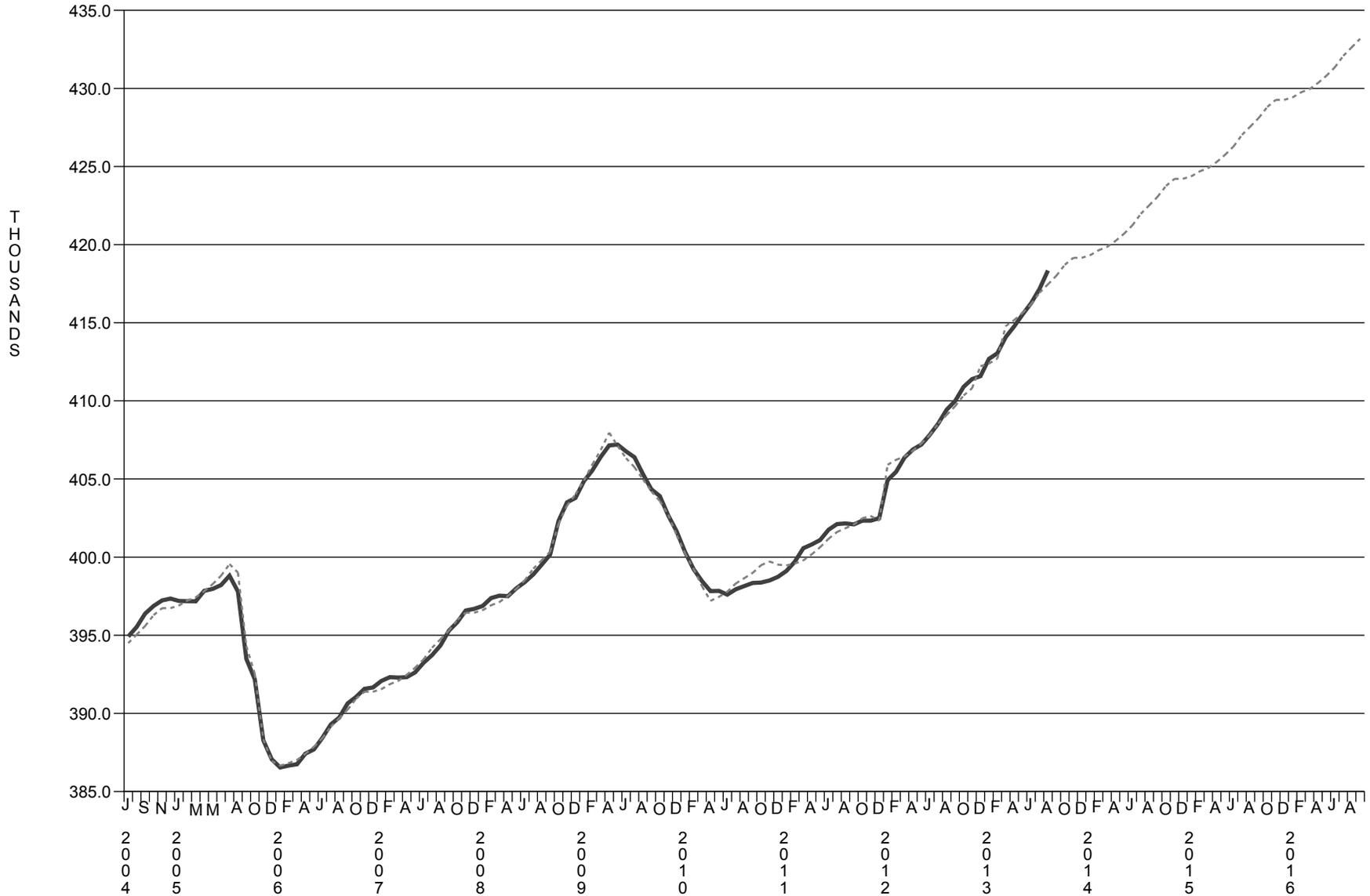
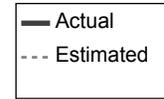
<sup>2</sup> The 1931(b) category of eligibility is included in MN-Families and PA-Families.

**STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: ALL AIDS**

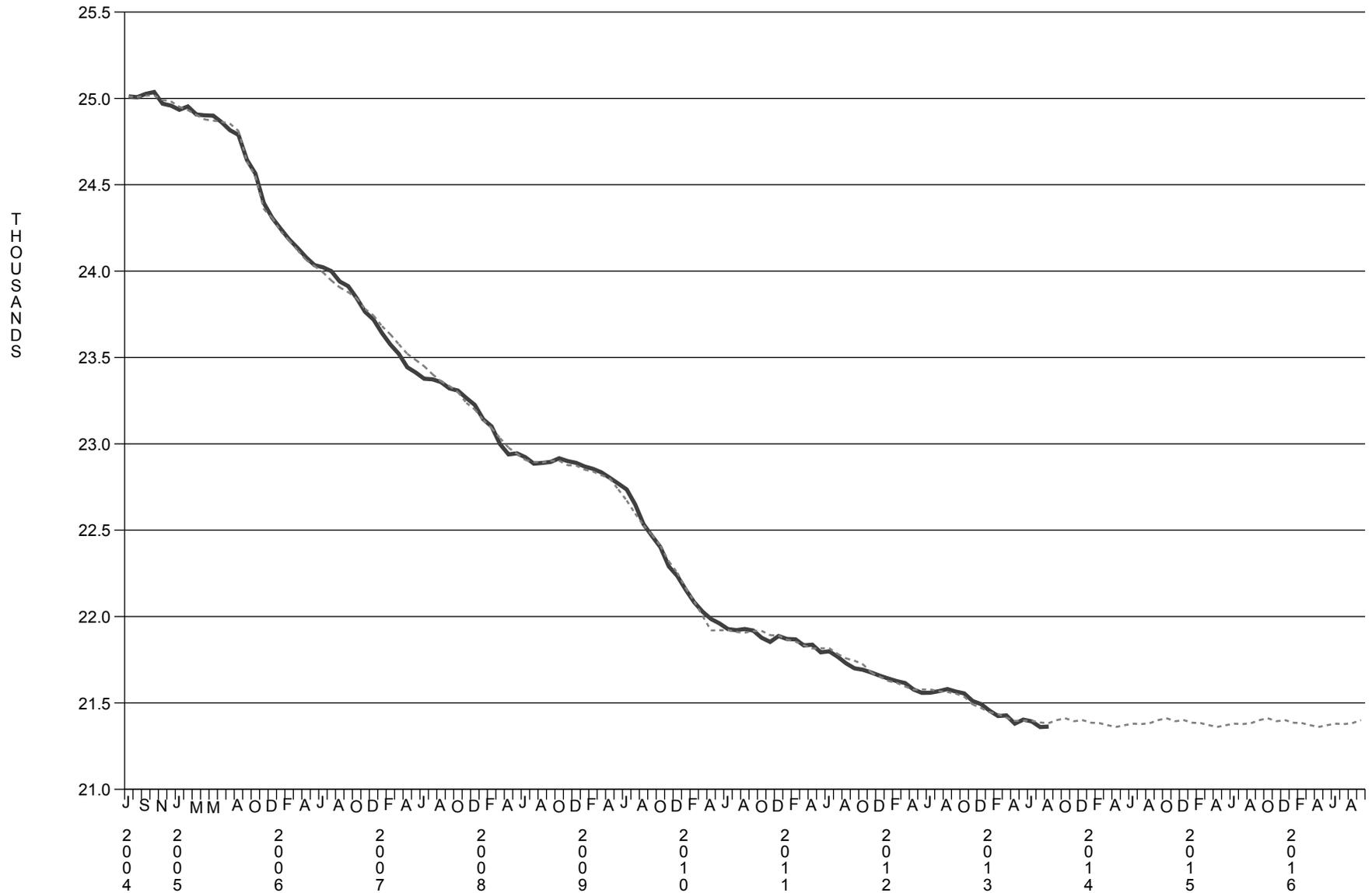
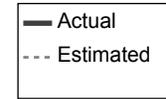
— Actual  
 - - - Estimated



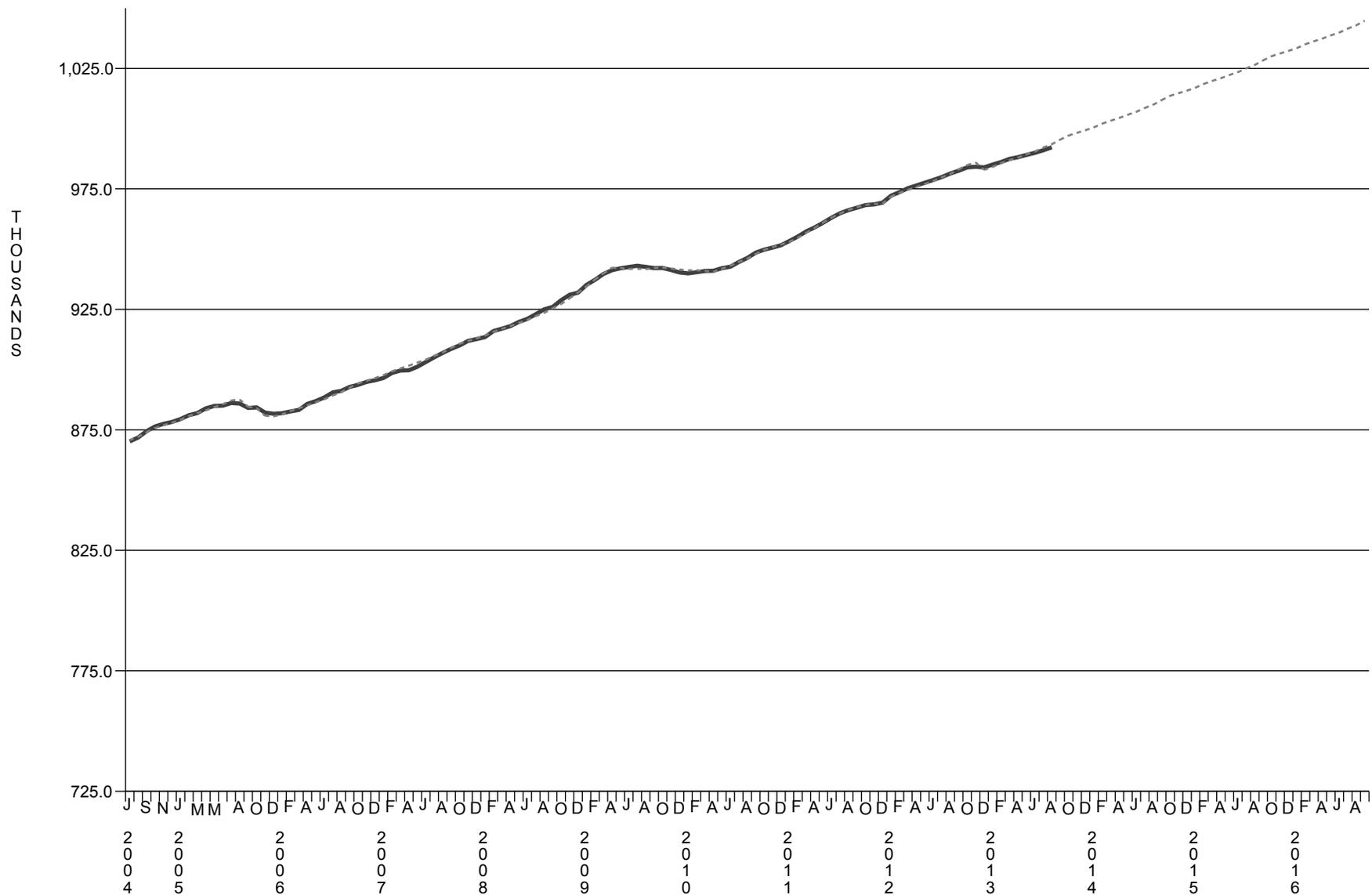
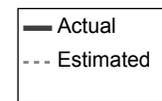
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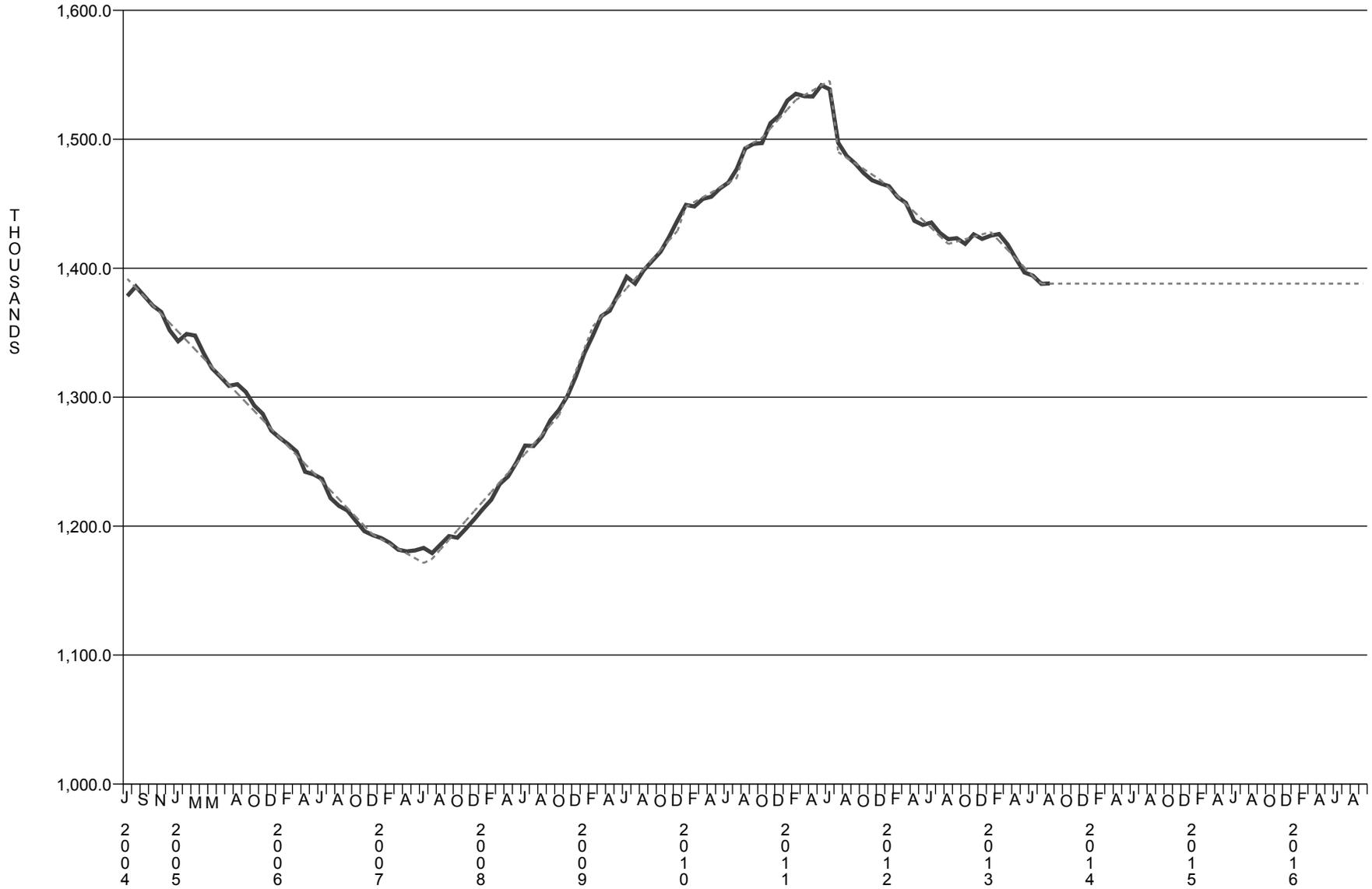
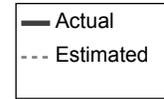
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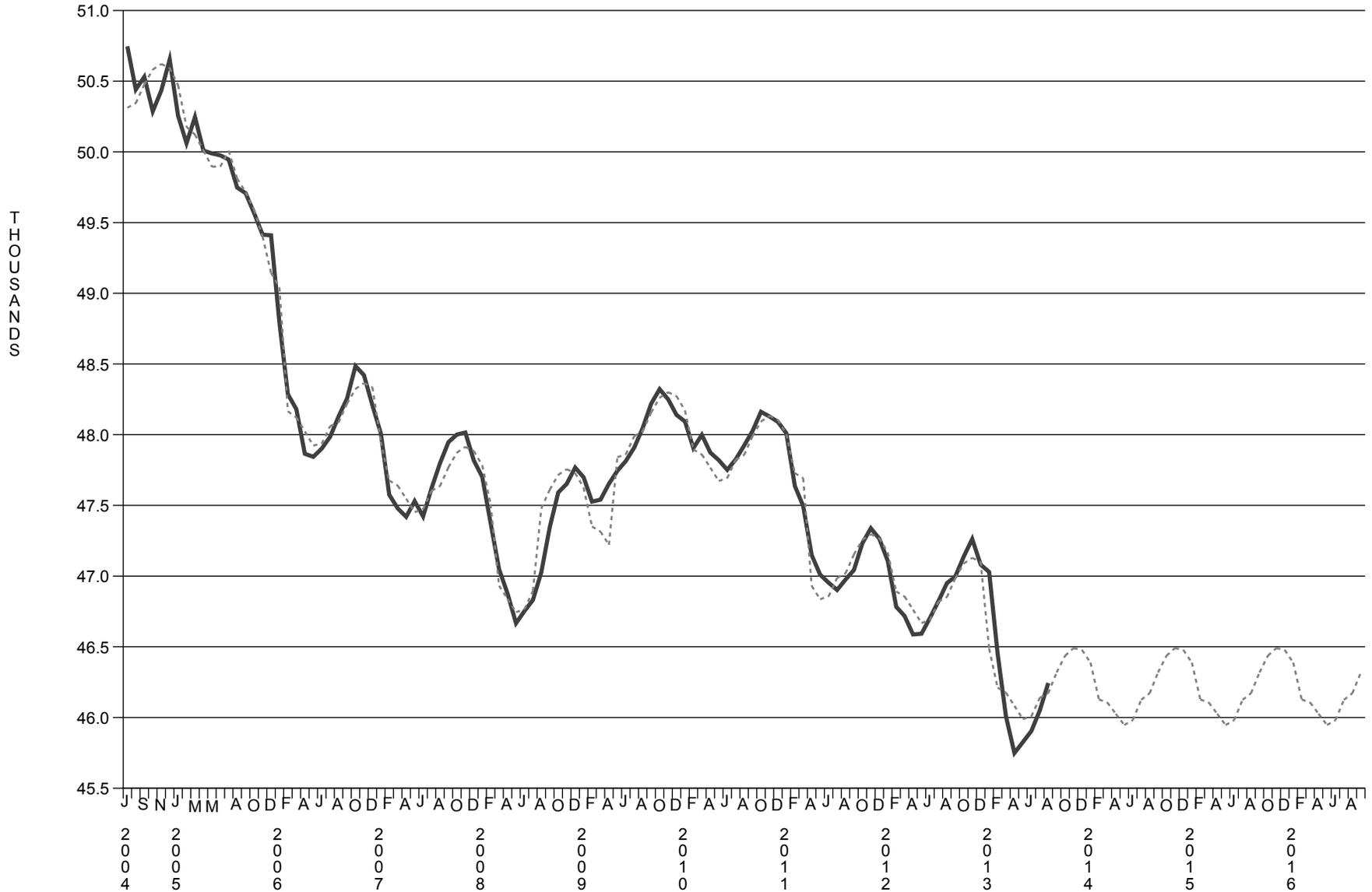
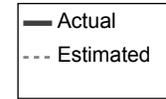
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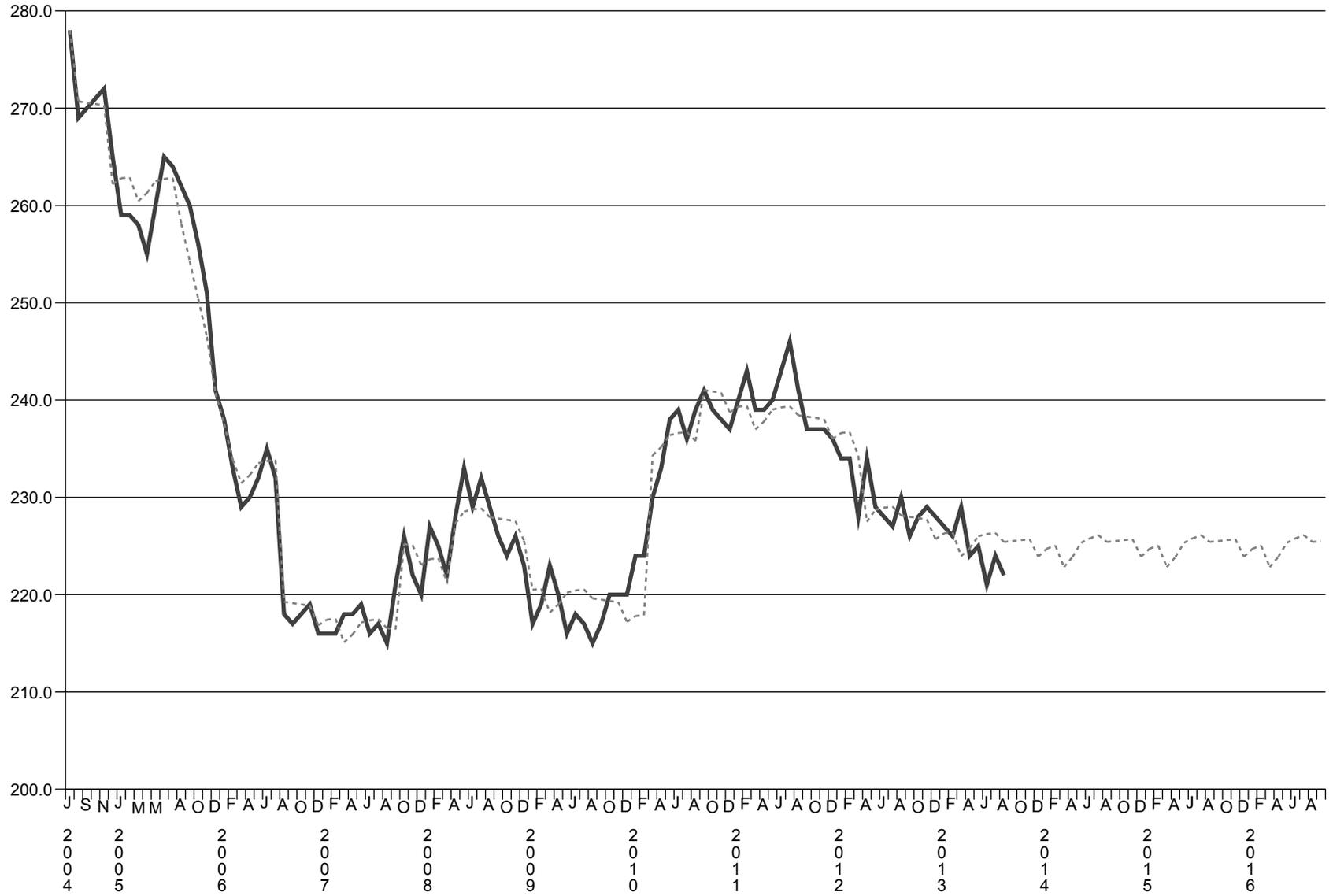
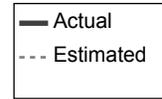
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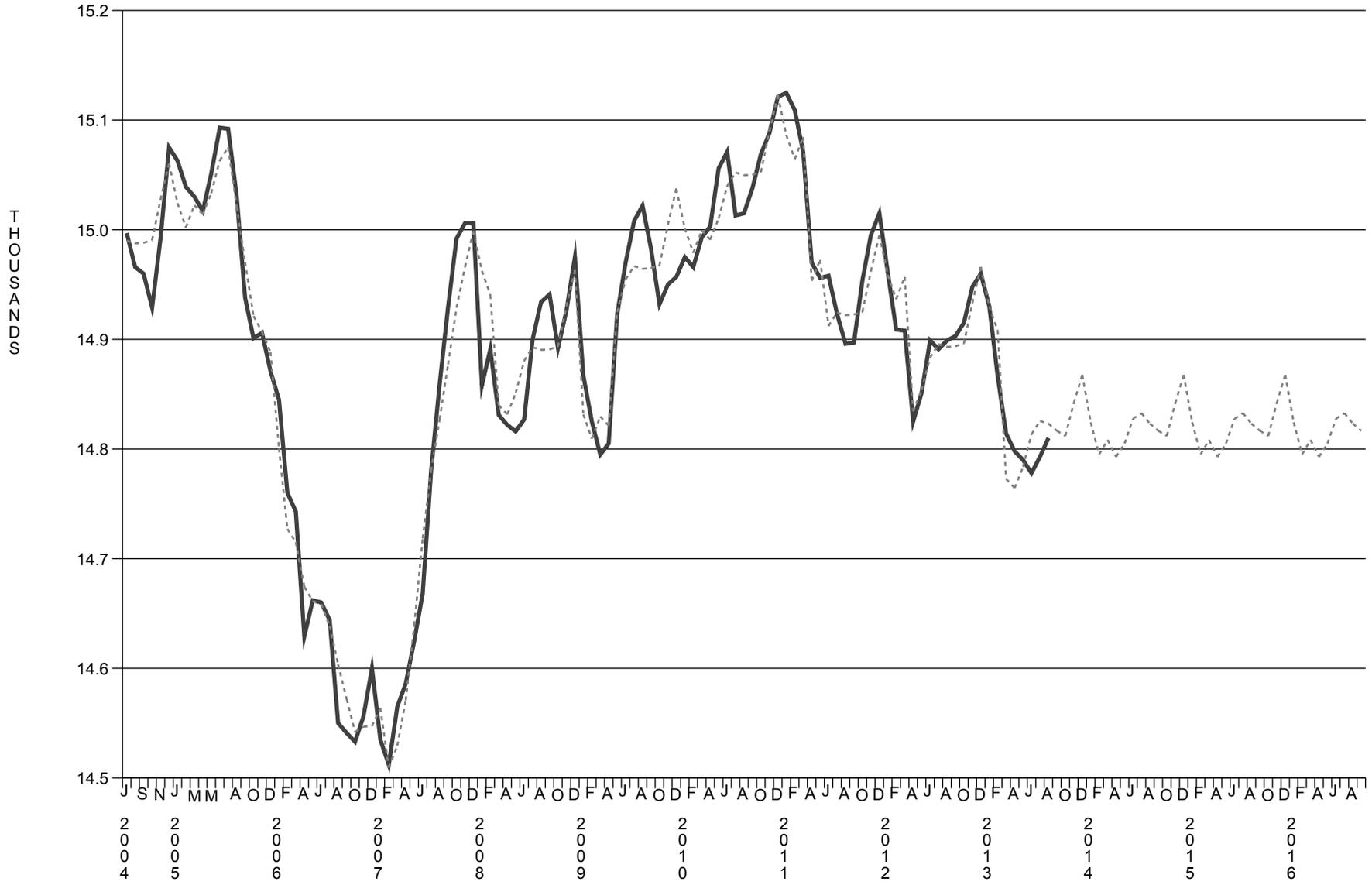
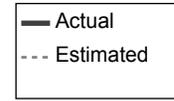
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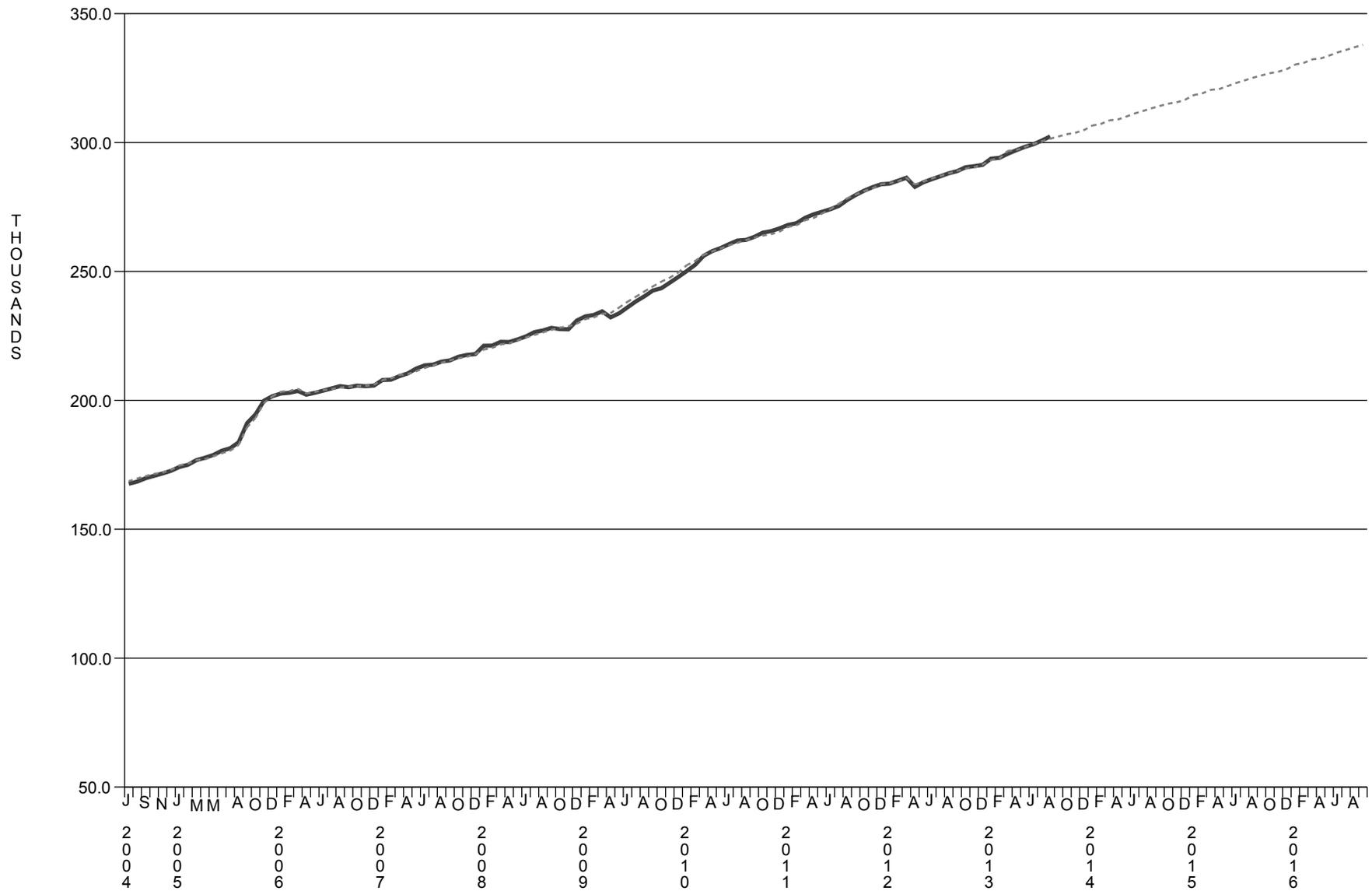
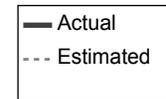
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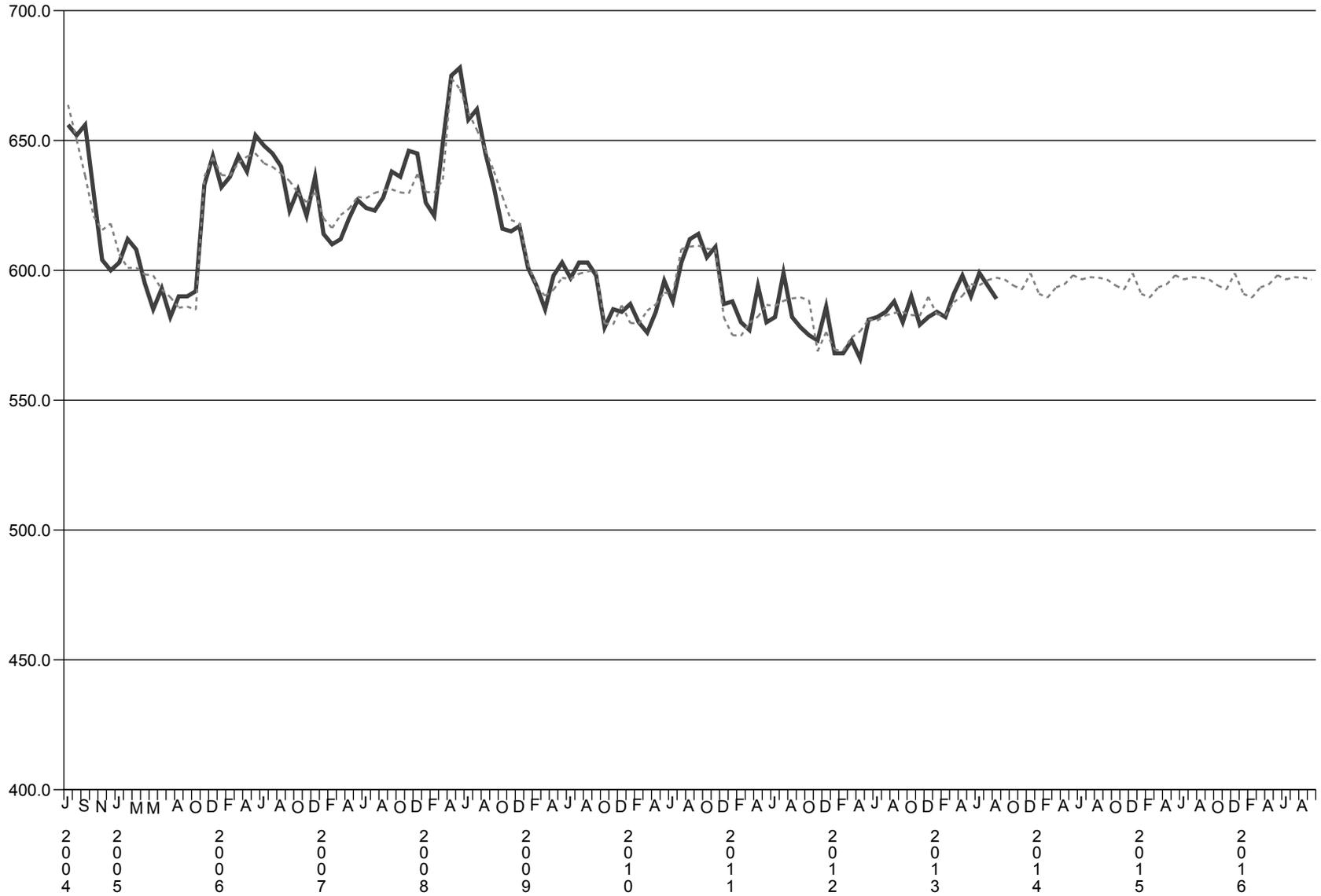
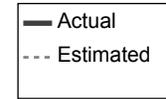
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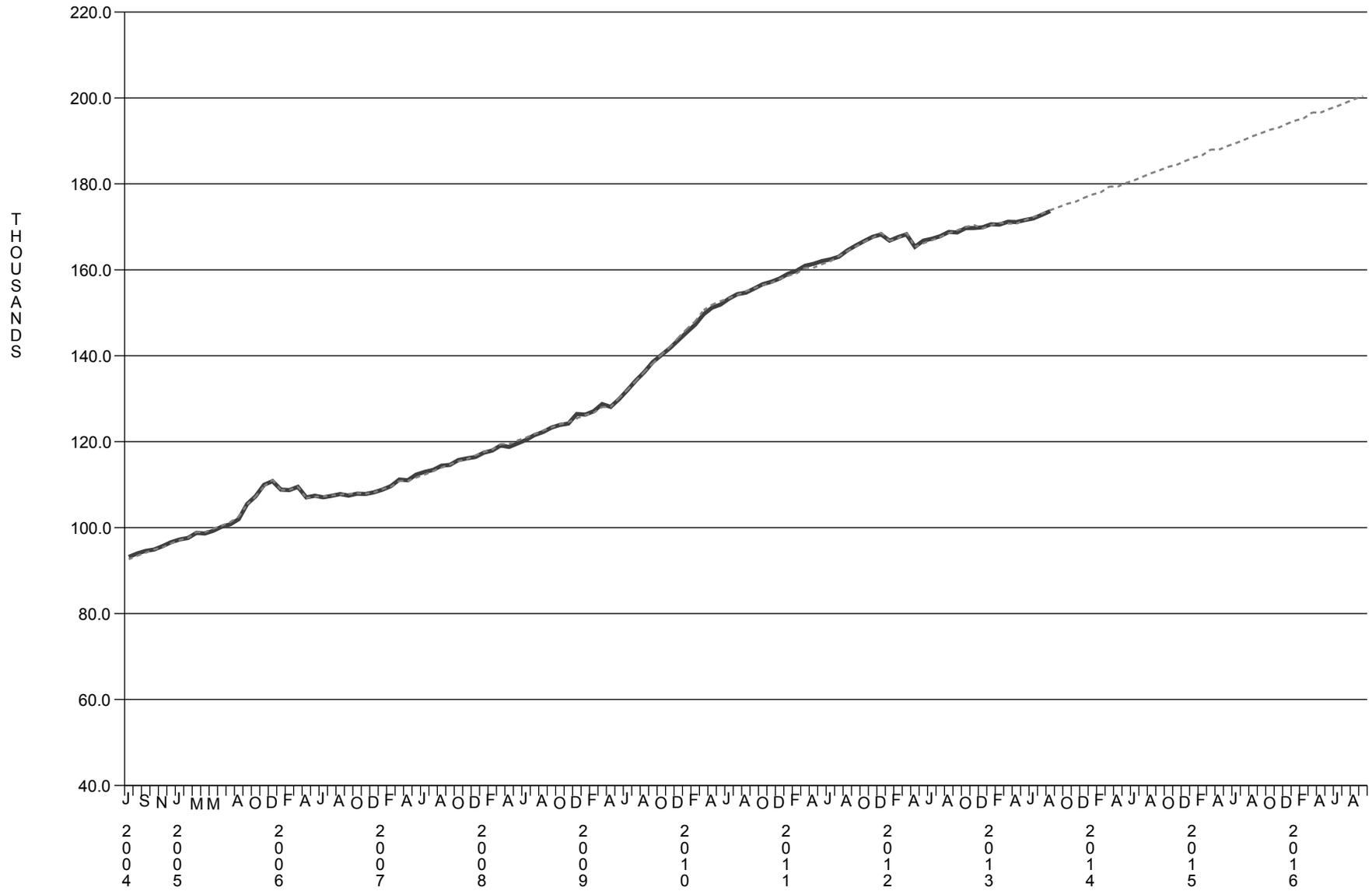
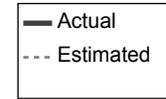
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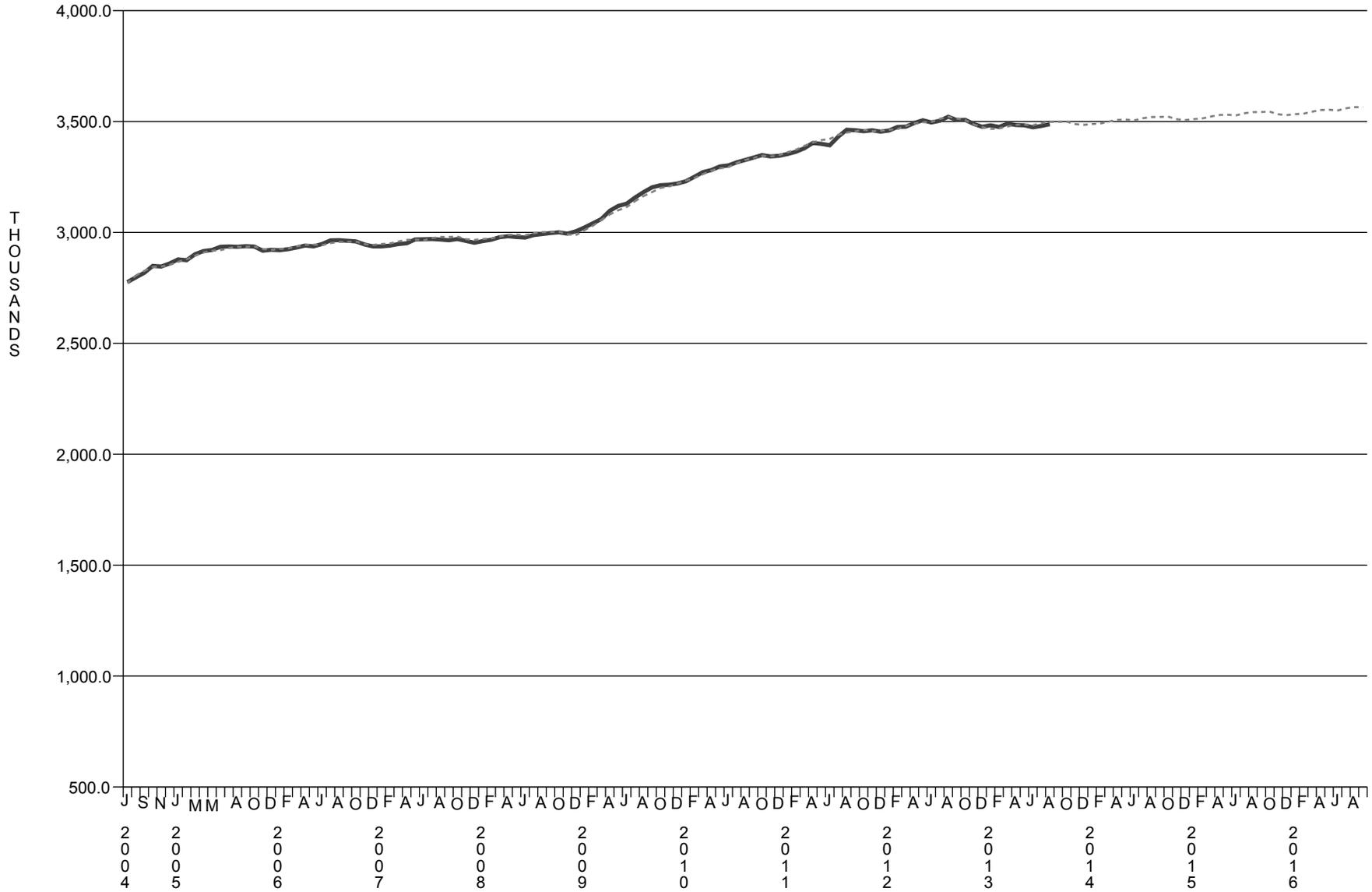
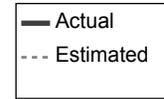
**STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MN-AB**



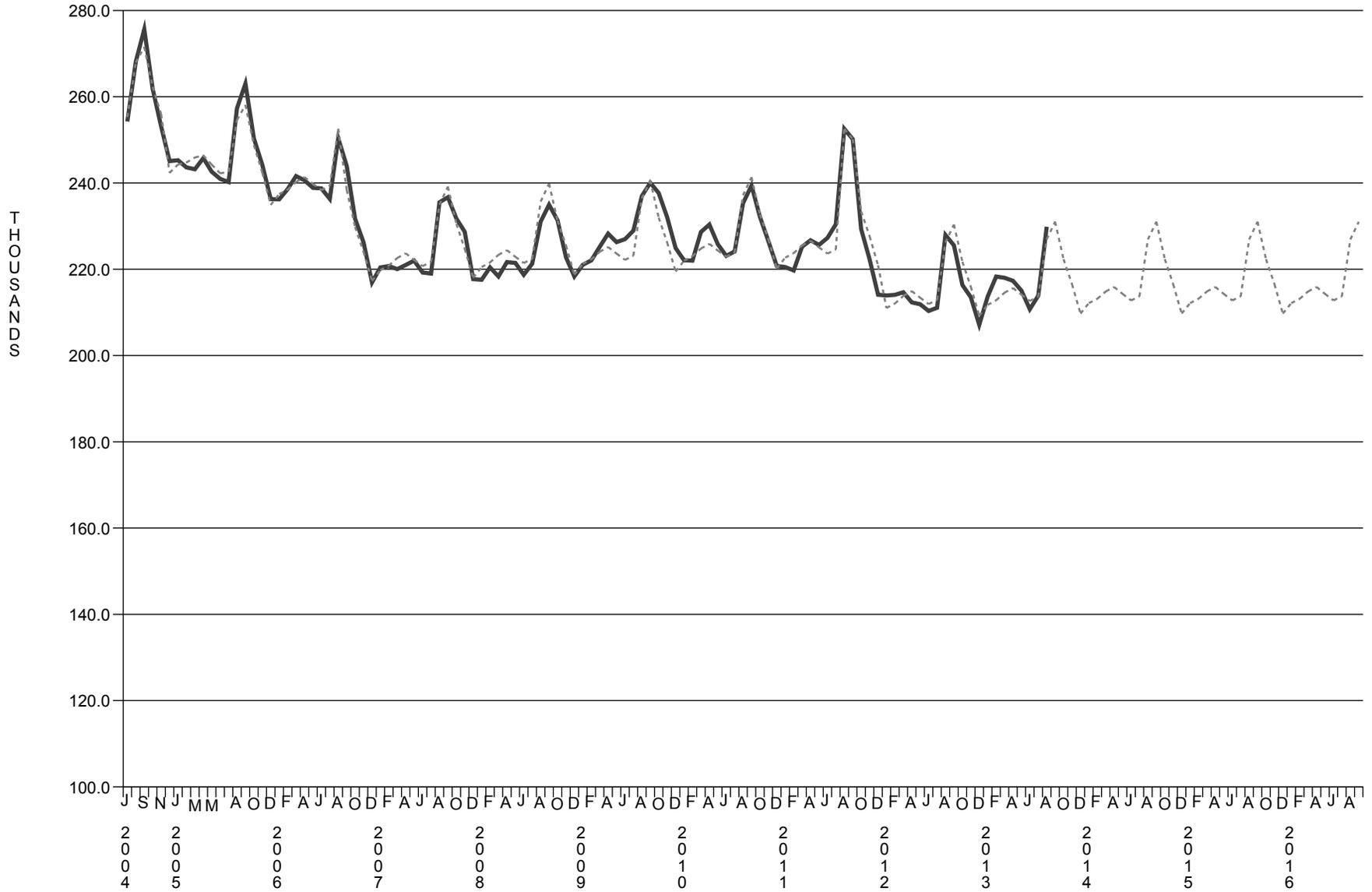
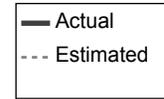
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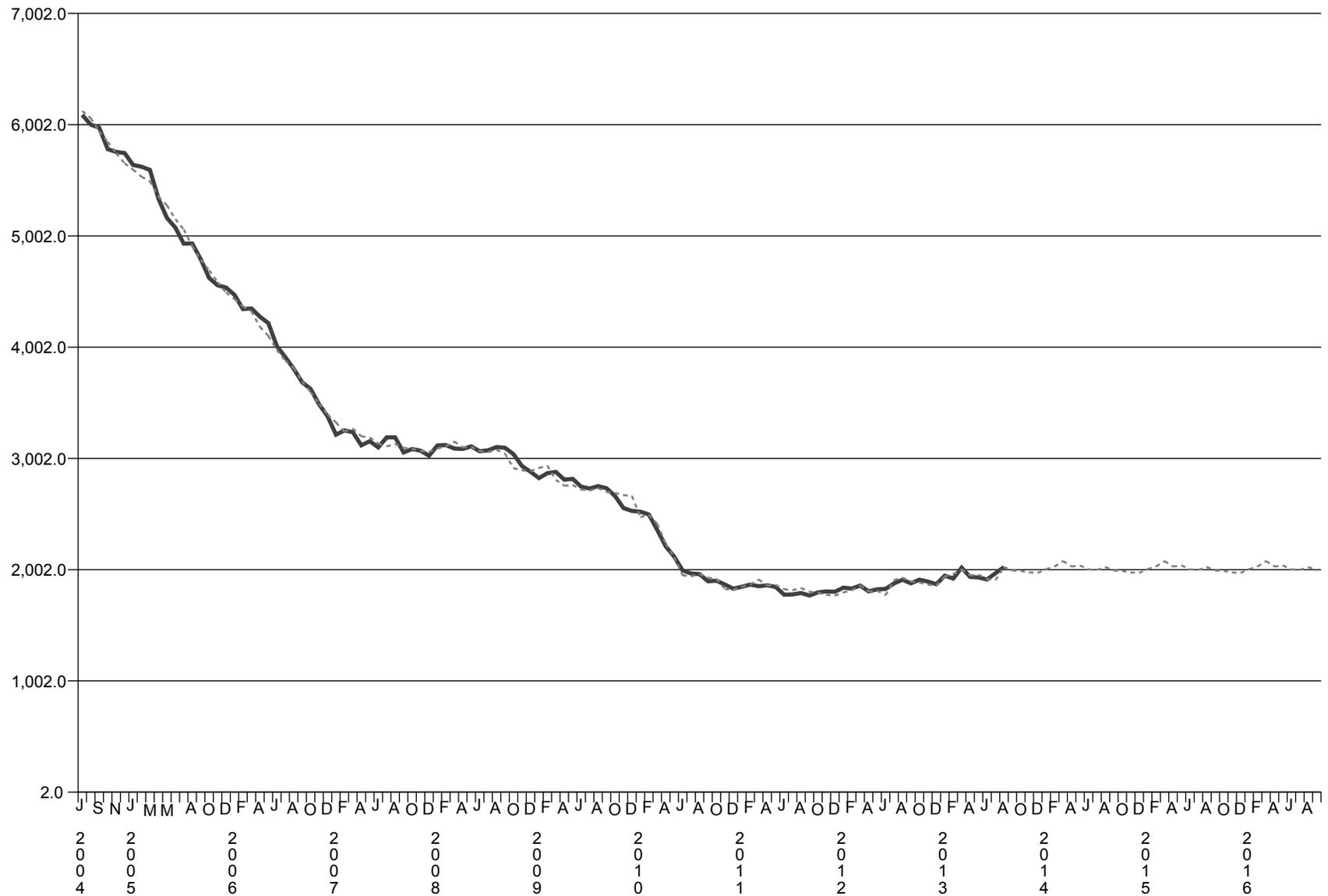
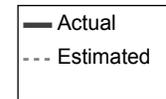
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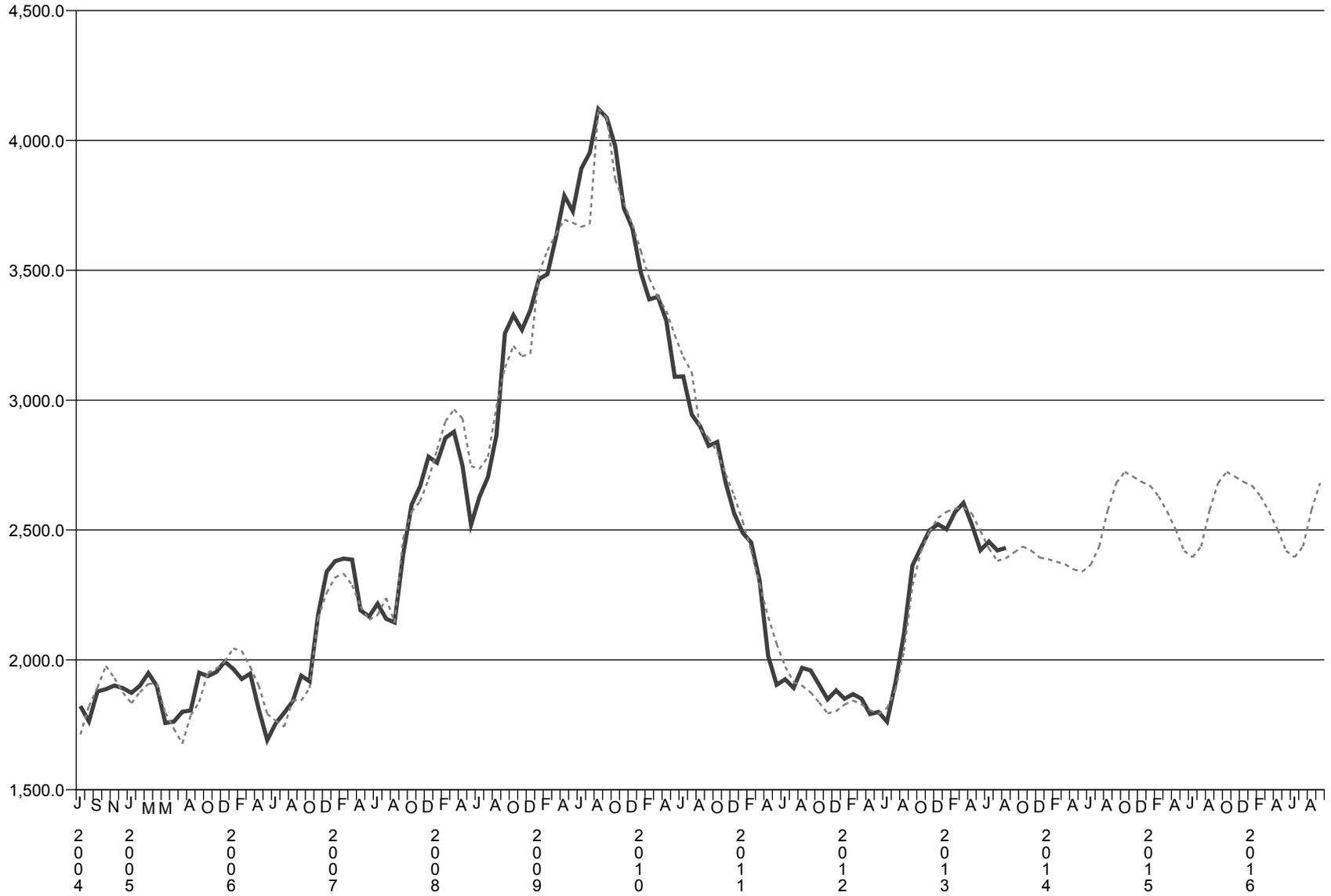
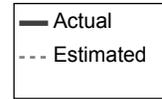
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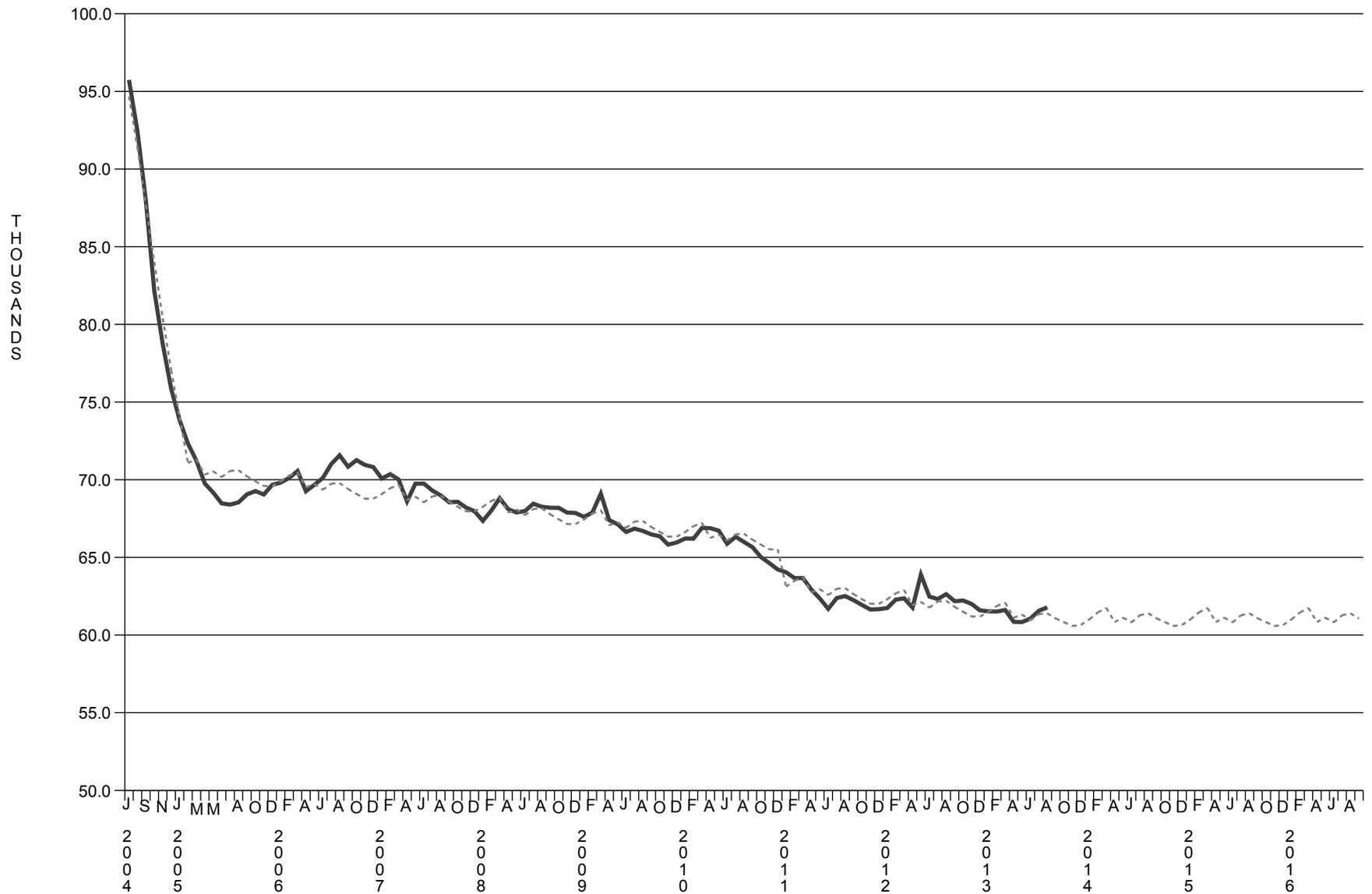
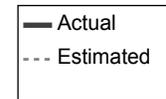
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**STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: REFUGEE**

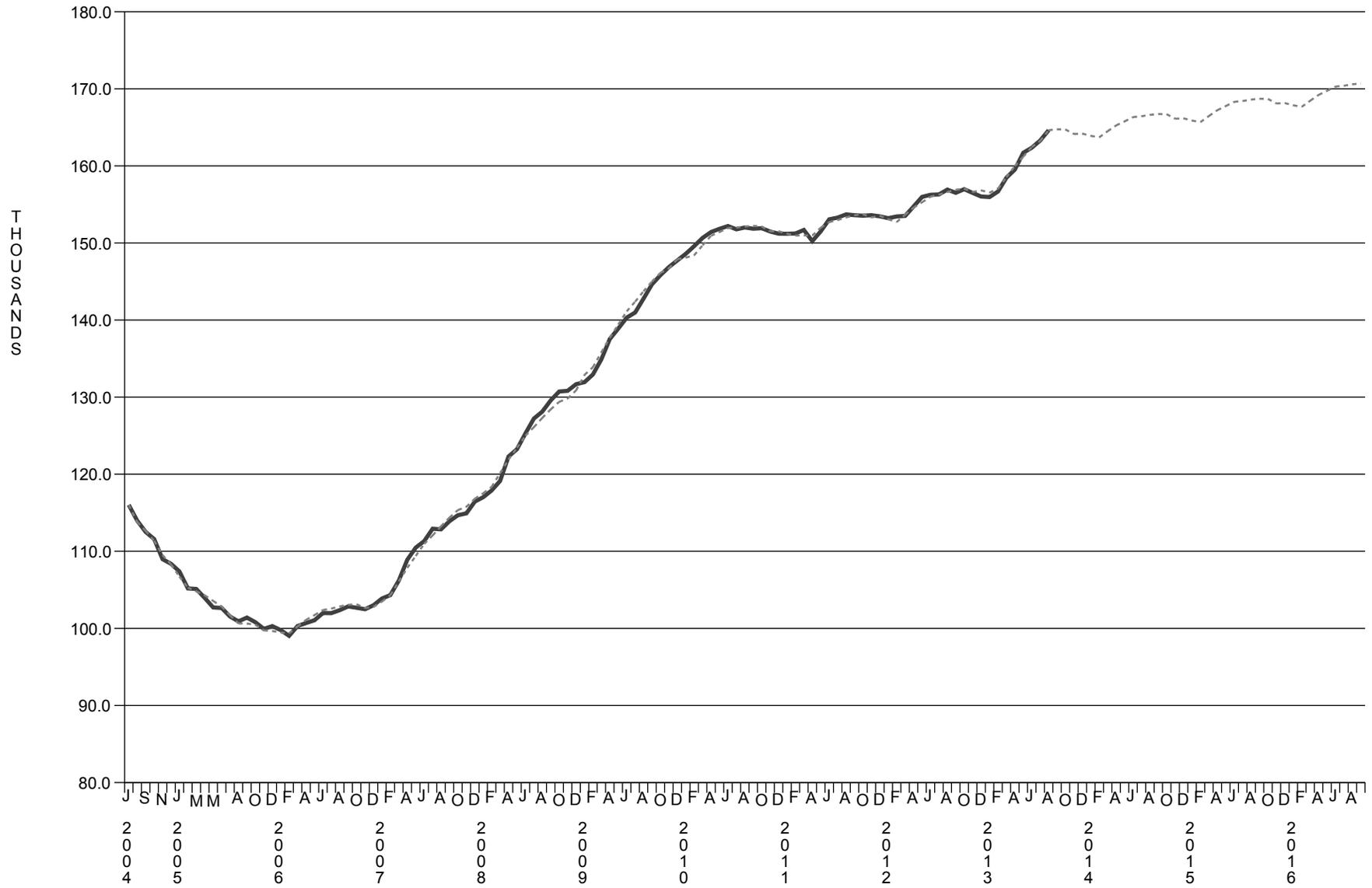
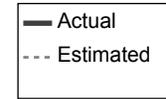


**STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: OBRA**

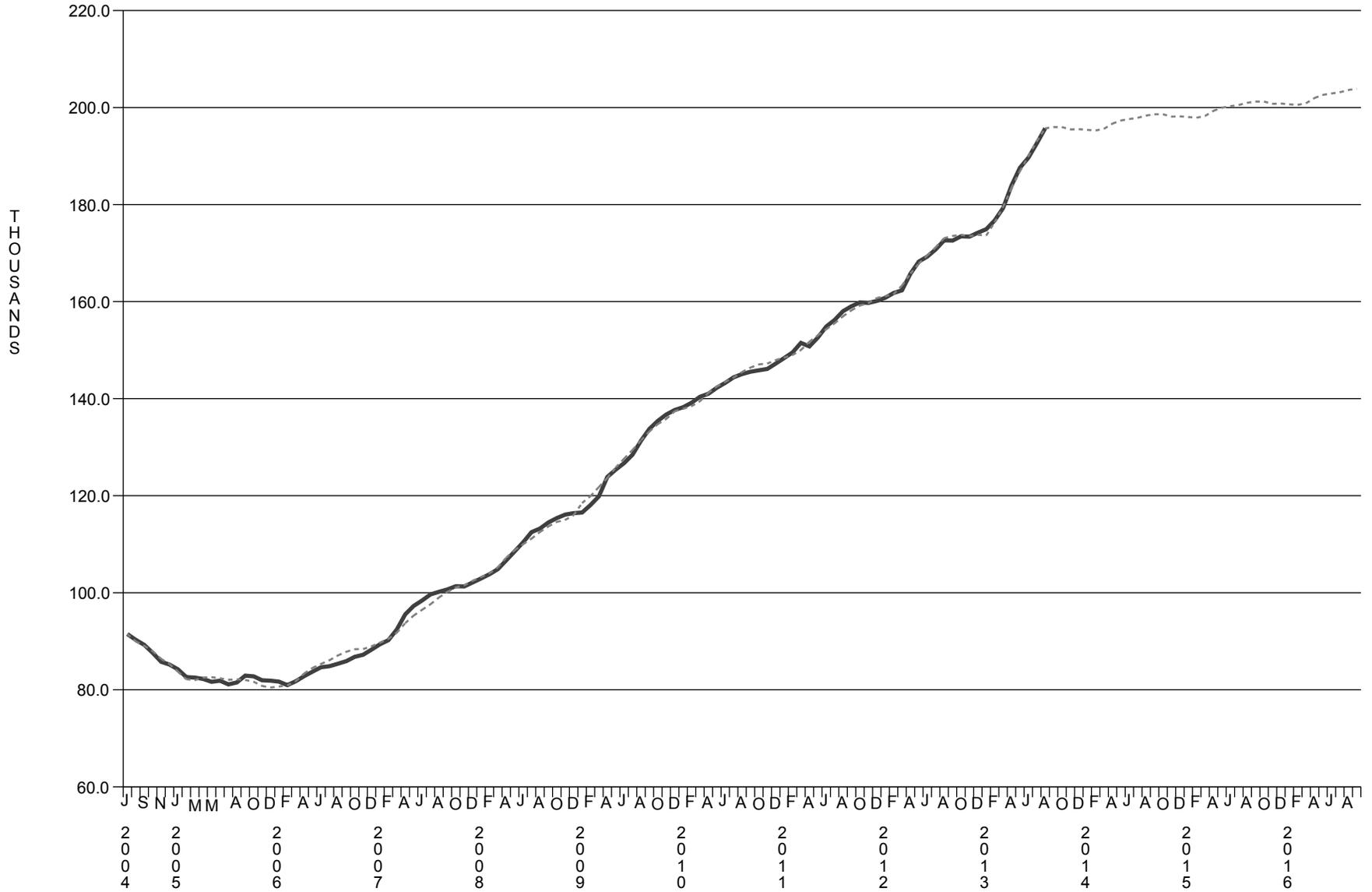
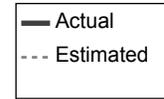




**STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: POV 133**



**STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: POV 100**



### **Medi-Cal Fee-For-Service Base Estimate**

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

The base estimate consists of two types. The first type, which has traditionally been called the Fee-for-Service Base (FFS Base) Estimate, is summarized in this section. The FFS Base includes the first 12 service categories (Physicians through Home Health) as displayed in most tables throughout this binder and listed below. The data used for these projections consist of claims that are paid through the main Medi-Cal claims processing system at the Fiscal Intermediary. These claims are paid on a fee-for-service basis.

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is described and included in the Base Policy Change section.

#### **FFS Base Estimate Service Categories:**

Physicians  
Other Medical  
County Outpatient  
Community Outpatient  
Pharmacy  
County Inpatient  
Community Inpatient  
Nursing Facilities  
Intermediate Care Facilities-Developmentally Disabled (ICF-DD)  
Medical Transportation  
Other Services  
Home Health

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**TOTAL FOR ALL SERVICES ACROSS ALL BASE AID CATEGORIES**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	1,694,380	4.92	\$163.78	\$806.13	\$4,097,683,600
2011-12 *	2	1,703,710	4.86	\$163.23	\$793.74	\$4,056,883,200
2011-12 *	3	1,698,310	4.74	\$163.66	\$776.08	\$3,954,105,400
2011-12 *	4	1,634,670	4.48	\$166.03	\$743.48	\$3,646,030,200
2011-12 *	TOTAL	1,682,770	4.75	\$164.12	\$780.20	\$15,754,702,400
2012-13 *	1	1,648,340	4.78	\$174.55	\$834.98	\$4,129,022,600
2012-13 *	2	1,636,930	4.55	\$180.49	\$821.10	\$4,032,249,500
2012-13 *	3	1,652,020	4.49	\$175.22	\$787.50	\$3,902,873,700
2012-13 *	4	1,495,030	4.27	\$171.85	\$734.51	\$3,294,346,500
2012-13 *	TOTAL	1,608,080	4.53	\$175.64	\$795.90	\$15,358,492,300
2013-14 **	1	1,721,120	4.94	\$180.14	\$890.75	\$4,599,265,400
2013-14 **	2	1,596,460	4.60	\$179.36	\$824.42	\$3,948,477,400
2013-14 **	3	1,621,470	4.57	\$177.57	\$811.57	\$3,947,812,700
2013-14 **	4	1,513,750	4.38	\$175.37	\$768.44	\$3,489,648,700
2013-14 **	TOTAL	1,613,200	4.63	\$178.25	\$825.75	\$15,985,204,200
2014-15 **	1	1,733,460	4.98	\$180.14	\$897.53	\$4,667,497,200
2014-15 **	2	1,596,780	4.63	\$181.75	\$841.45	\$4,030,824,800
2014-15 **	3	1,622,530	4.60	\$179.82	\$827.72	\$4,028,977,100
2014-15 **	4	1,515,040	4.41	\$177.18	\$782.15	\$3,554,969,300
2014-15 **	TOTAL	1,616,950	4.67	\$179.80	\$839.14	\$16,282,268,400

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**PHYSICIANS**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	510,640	2.20	\$77.22	\$169.52	\$259,698,100
2011-12 *	2	489,160	2.18	\$77.28	\$168.39	\$247,106,200
2011-12 *	3	526,730	2.10	\$76.13	\$159.80	\$252,514,900
2011-12 *	4	474,380	2.08	\$74.30	\$154.37	\$219,686,900
2011-12 *	TOTAL	500,230	2.14	\$76.28	\$163.09	\$979,006,100
2012-13 *	1	459,480	2.20	\$78.04	\$172.04	\$237,154,500
2012-13 *	2	425,170	2.15	\$77.16	\$166.25	\$212,060,100
2012-13 *	3	490,650	2.09	\$74.63	\$156.03	\$229,660,600
2012-13 *	4	418,510	2.08	\$72.52	\$150.47	\$188,924,600
2012-13 *	TOTAL	448,450	2.13	\$75.66	\$161.26	\$867,799,800
2013-14 **	1	473,720	2.27	\$75.73	\$171.89	\$244,287,300
2013-14 **	2	403,600	2.18	\$75.94	\$165.70	\$200,629,900
2013-14 **	3	468,990	2.09	\$74.07	\$154.68	\$217,635,000
2013-14 **	4	407,360	2.09	\$73.50	\$153.24	\$187,274,600
2013-14 **	TOTAL	438,420	2.16	\$74.85	\$161.53	\$849,826,800
2014-15 **	1	470,300	2.31	\$76.10	\$176.13	\$248,497,100
2014-15 **	2	405,650	2.19	\$76.03	\$166.80	\$202,994,400
2014-15 **	3	471,130	2.10	\$74.14	\$155.73	\$220,105,900
2014-15 **	4	409,510	2.10	\$73.57	\$154.23	\$189,480,500
2014-15 **	TOTAL	439,150	2.18	\$75.01	\$163.40	\$861,077,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**OTHER MEDICAL**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	692,760	1.75	\$119.04	\$208.47	\$433,265,600
2011-12 *	2	694,660	1.67	\$131.30	\$218.97	\$456,333,000
2011-12 *	3	689,160	1.69	\$126.76	\$213.74	\$441,913,500
2011-12 *	4	662,460	1.63	\$134.67	\$219.62	\$436,476,100
2011-12 *	TOTAL	684,760	1.68	\$127.72	\$215.16	\$1,767,988,100
2012-13 *	1	708,590	1.68	\$129.05	\$216.89	\$461,047,500
2012-13 *	2	705,620	1.63	\$132.09	\$215.83	\$456,868,200
2012-13 *	3	725,630	1.63	\$132.47	\$215.93	\$470,057,700
2012-13 *	4	637,630	1.60	\$141.51	\$226.31	\$432,897,800
2012-13 *	TOTAL	694,370	1.64	\$133.51	\$218.53	\$1,820,871,200
2013-14 **	1	791,700	1.70	\$155.37	\$263.68	\$626,259,600
2013-14 **	2	723,710	1.62	\$137.48	\$223.29	\$484,799,700
2013-14 **	3	724,730	1.62	\$135.91	\$219.91	\$478,122,500
2013-14 **	4	656,490	1.59	\$136.77	\$217.49	\$428,333,400
2013-14 **	TOTAL	724,160	1.63	\$142.01	\$232.17	\$2,017,515,100
2014-15 **	1	800,020	1.72	\$134.99	\$232.15	\$557,170,600
2014-15 **	2	723,020	1.63	\$137.45	\$223.79	\$485,417,800
2014-15 **	3	724,300	1.62	\$135.86	\$220.33	\$478,751,600
2014-15 **	4	656,150	1.59	\$136.54	\$217.71	\$428,541,400
2014-15 **	TOTAL	725,870	1.64	\$136.15	\$223.86	\$1,949,881,300

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**COUNTY OUTPATIENT**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	39,580	1.71	\$94.36	\$161.29	\$19,152,800
2011-12 *	2	33,250	1.75	\$104.01	\$181.53	\$18,106,000
2011-12 *	3	28,000	1.71	\$107.12	\$183.04	\$15,377,100
2011-12 *	4	24,570	1.65	\$95.08	\$156.55	\$11,538,200
2011-12 *	TOTAL	31,350	1.71	\$99.97	\$170.59	\$64,174,200
2012-13 *	1	23,850	1.69	\$118.01	\$199.54	\$14,279,200
2012-13 *	2	25,090	1.86	\$93.61	\$174.16	\$13,109,800
2012-13 *	3	20,510	1.63	\$123.15	\$201.08	\$12,374,200
2012-13 *	4	20,880	1.70	\$110.14	\$187.66	\$11,755,000
2012-13 *	TOTAL	22,580	1.73	\$110.02	\$190.09	\$51,518,200
2013-14 **	1	25,810	1.72	\$116.07	\$200.12	\$15,495,200
2013-14 **	2	23,860	1.73	\$114.06	\$197.59	\$14,141,500
2013-14 **	3	24,340	1.70	\$113.55	\$192.74	\$14,073,300
2013-14 **	4	23,500	1.72	\$100.61	\$172.60	\$12,169,500
2013-14 **	TOTAL	24,380	1.72	\$111.23	\$191.02	\$55,879,500
2014-15 **	1	28,160	1.78	\$108.68	\$193.55	\$16,353,900
2014-15 **	2	23,940	1.74	\$113.82	\$197.81	\$14,207,000
2014-15 **	3	24,460	1.70	\$113.36	\$193.10	\$14,170,200
2014-15 **	4	23,640	1.72	\$100.62	\$173.17	\$12,281,700
2014-15 **	TOTAL	25,050	1.74	\$109.15	\$189.65	\$57,012,700

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**COMMUNITY OUTPATIENT**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	253,530	1.54	\$95.98	\$147.60	\$112,262,100
2011-12 *	2	250,370	1.54	\$98.46	\$151.83	\$114,039,900
2011-12 *	3	236,430	1.54	\$99.82	\$153.69	\$109,009,500
2011-12 *	4	231,760	1.54	\$96.14	\$148.11	\$102,975,900
2011-12 *	TOTAL	243,020	1.54	\$97.59	\$150.29	\$438,287,300
2012-13 *	1	196,180	1.56	\$118.24	\$184.48	\$108,575,600
2012-13 *	2	242,000	1.73	\$92.69	\$160.19	\$116,301,000
2012-13 *	3	190,890	1.63	\$105.72	\$172.80	\$98,956,000
2012-13 *	4	181,950	1.67	\$95.01	\$158.46	\$86,494,300
2012-13 *	TOTAL	202,750	1.65	\$102.09	\$168.65	\$410,326,900
2013-14 **	1	236,170	1.61	\$107.60	\$173.17	\$122,693,700
2013-14 **	2	219,480	1.55	\$95.79	\$148.53	\$97,795,900
2013-14 **	3	216,330	1.53	\$101.42	\$154.71	\$100,401,200
2013-14 **	4	207,660	1.54	\$94.92	\$145.80	\$90,831,600
2013-14 **	TOTAL	219,910	1.56	\$100.22	\$156.02	\$411,722,400
2014-15 **	1	254,460	1.63	\$97.23	\$158.40	\$120,923,900
2014-15 **	2	220,140	1.56	\$95.48	\$148.58	\$98,125,700
2014-15 **	3	217,040	1.53	\$101.08	\$154.74	\$100,751,500
2014-15 **	4	208,470	1.54	\$94.26	\$145.12	\$90,759,000
2014-15 **	TOTAL	225,030	1.57	\$97.04	\$152.04	\$410,560,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**PHARMACY**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	729,050	3.48	\$88.19	\$306.82	\$671,056,300
2011-12 *	2	741,260	3.39	\$90.14	\$305.40	\$679,153,400
2011-12 *	3	707,390	3.22	\$90.55	\$292.01	\$619,699,200
2011-12 *	4	640,020	2.92	\$98.01	\$286.47	\$550,034,500
2011-12 *	TOTAL	704,430	3.26	\$91.31	\$298.11	\$2,519,943,400
2012-13 *	1	660,670	3.10	\$103.60	\$321.48	\$637,174,200
2012-13 *	2	645,370	2.96	\$100.85	\$298.49	\$577,911,000
2012-13 *	3	626,290	2.97	\$106.91	\$317.96	\$597,397,100
2012-13 *	4	523,830	2.89	\$111.52	\$321.92	\$505,884,100
2012-13 *	TOTAL	614,040	2.99	\$105.36	\$314.63	\$2,318,366,500
2013-14 **	1	617,690	3.25	\$116.18	\$377.52	\$699,566,200
2013-14 **	2	600,510	3.06	\$116.60	\$356.30	\$641,879,900
2013-14 **	3	602,360	3.01	\$116.65	\$351.06	\$634,392,600
2013-14 **	4	526,230	2.88	\$120.60	\$346.84	\$547,556,300
2013-14 **	TOTAL	586,700	3.05	\$117.34	\$358.42	\$2,523,395,000
2014-15 **	1	628,830	3.31	\$124.66	\$412.05	\$777,327,000
2014-15 **	2	600,480	3.06	\$125.05	\$382.24	\$688,588,300
2014-15 **	3	602,330	3.01	\$124.94	\$376.15	\$679,696,800
2014-15 **	4	526,200	2.87	\$128.68	\$369.88	\$583,894,000
2014-15 **	TOTAL	589,460	3.07	\$125.67	\$385.88	\$2,729,506,000

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of prescriptions

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**COUNTY INPATIENT**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	5,920	5.80	\$1,766.79	\$10,252.86	\$182,029,200
2011-12 *	2	5,750	5.54	\$1,696.34	\$9,396.67	\$161,998,500
2011-12 *	3	5,250	5.52	\$1,657.63	\$9,145.87	\$144,138,800
2011-12 *	4	5,210	6.20	\$1,535.31	\$9,513.42	\$148,656,700
2011-12 *	TOTAL	5,530	5.76	\$1,665.74	\$9,593.60	\$636,823,300
2012-13 *	1	6,380	6.00	\$1,565.09	\$9,389.41	\$179,816,700
2012-13 *	2	6,830	5.89	\$1,562.82	\$9,200.97	\$188,564,700
2012-13 *	3	5,750	5.61	\$1,563.86	\$8,779.17	\$151,554,800
2012-13 *	4	4,770	5.43	\$1,605.46	\$8,711.09	\$124,559,900
2012-13 *	TOTAL	5,930	5.76	\$1,571.77	\$9,051.02	\$644,496,100
2013-14 **	1	5,230	5.44	\$1,630.25	\$8,865.83	\$139,003,300
2013-14 **	2	5,400	5.49	\$1,631.68	\$8,960.37	\$145,143,300
2013-14 **	3	5,370	5.44	\$1,630.70	\$8,874.81	\$142,944,000
2013-14 **	4	4,590	5.60	\$1,628.50	\$9,124.78	\$125,690,700
2013-14 **	TOTAL	5,150	5.49	\$1,630.34	\$8,950.72	\$552,781,200
2014-15 **	1	5,630	5.69	\$1,627.23	\$9,255.73	\$156,227,700
2014-15 **	2	5,400	5.49	\$1,631.68	\$8,960.37	\$145,143,300
2014-15 **	3	5,370	5.44	\$1,630.70	\$8,874.81	\$142,944,000
2014-15 **	4	4,590	5.61	\$1,625.29	\$9,118.49	\$125,604,000
2014-15 **	TOTAL	5,250	5.56	\$1,628.80	\$9,052.26	\$569,919,000

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**COMMUNITY INPATIENT**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	47,750	3.56	\$1,942.07	\$6,913.79	\$990,468,900
2011-12 *	2	43,540	3.57	\$1,968.85	\$7,025.75	\$917,626,300
2011-12 *	3	43,670	3.60	\$1,966.31	\$7,079.67	\$927,507,300
2011-12 *	4	43,120	3.49	\$1,920.17	\$6,694.67	\$866,001,800
2011-12 *	TOTAL	44,520	3.55	\$1,949.46	\$6,928.78	\$3,701,604,300
2012-13 *	1	45,840	3.40	\$2,019.98	\$6,865.53	\$944,209,000
2012-13 *	2	43,580	3.42	\$2,026.58	\$6,929.72	\$905,894,900
2012-13 *	3	44,340	3.43	\$2,036.57	\$6,979.98	\$928,427,500
2012-13 *	4	37,530	3.51	\$2,021.14	\$7,089.20	\$798,081,400
2012-13 *	TOTAL	42,820	3.44	\$2,026.19	\$6,960.49	\$3,576,612,800
2013-14 **	1	46,950	3.64	\$1,996.53	\$7,268.81	\$1,023,854,000
2013-14 **	2	41,750	3.57	\$2,060.22	\$7,357.55	\$921,564,600
2013-14 **	3	42,630	3.56	\$2,060.64	\$7,338.85	\$938,461,700
2013-14 **	4	37,470	3.50	\$2,070.49	\$7,253.25	\$815,281,100
2013-14 **	TOTAL	42,200	3.57	\$2,044.51	\$7,305.00	\$3,699,161,300
2014-15 **	1	47,900	3.63	\$2,098.80	\$7,617.42	\$1,094,649,100
2014-15 **	2	41,750	3.57	\$2,099.90	\$7,499.26	\$939,313,700
2014-15 **	3	42,630	3.56	\$2,099.75	\$7,478.12	\$956,270,700
2014-15 **	4	37,470	3.50	\$2,107.48	\$7,383.90	\$829,965,800
2014-15 **	TOTAL	42,440	3.57	\$2,101.19	\$7,501.83	\$3,820,199,300

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**NURSING FACILITIES**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	63,000	29.82	\$177.45	\$5,292.33	\$1,000,229,700
2011-12 *	2	62,960	30.82	\$176.46	\$5,437.91	\$1,027,030,500
2011-12 *	3	61,500	31.02	\$176.76	\$5,483.90	\$1,011,702,700
2011-12 *	4	62,450	29.06	\$171.70	\$4,989.10	\$934,707,900
2011-12 *	TOTAL	62,470	30.18	\$175.64	\$5,300.37	\$3,973,670,800
2012-13 *	1	63,170	32.72	\$177.16	\$5,795.99	\$1,098,473,900
2012-13 *	2	62,490	30.98	\$202.09	\$6,260.26	\$1,173,623,400
2012-13 *	3	62,110	31.62	\$180.84	\$5,717.56	\$1,065,371,000
2012-13 *	4	55,030	27.33	\$182.72	\$4,993.27	\$824,324,000
2012-13 *	TOTAL	60,700	30.77	\$185.71	\$5,713.49	\$4,161,792,300
2013-14 **	1	64,010	37.19	\$180.92	\$6,727.45	\$1,291,937,300
2013-14 **	2	62,110	31.73	\$182.93	\$5,803.91	\$1,081,460,900
2013-14 **	3	61,490	31.50	\$182.55	\$5,750.72	\$1,060,803,800
2013-14 **	4	60,770	28.45	\$182.95	\$5,205.30	\$948,925,100
2013-14 **	TOTAL	62,090	32.28	\$182.25	\$5,882.31	\$4,383,127,100
2014-15 **	1	63,600	35.86	\$183.02	\$6,562.30	\$1,252,001,400
2014-15 **	2	62,110	31.73	\$182.93	\$5,803.91	\$1,081,460,900
2014-15 **	3	61,490	31.50	\$182.55	\$5,750.72	\$1,060,803,800
2014-15 **	4	60,770	28.44	\$182.90	\$5,201.02	\$948,145,900
2014-15 **	TOTAL	61,990	31.92	\$182.86	\$5,837.48	\$4,342,411,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**ICF-DD**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	5,340	29.97	\$180.46	\$5,408.89	\$86,607,100
2011-12 *	2	5,370	32.48	\$180.97	\$5,877.47	\$94,656,700
2011-12 *	3	5,430	31.12	\$181.55	\$5,650.34	\$92,066,600
2011-12 *	4	5,480	28.29	\$181.19	\$5,125.55	\$84,264,000
2011-12 *	TOTAL	5,400	30.46	\$181.05	\$5,514.09	\$357,594,400
2012-13 *	1	5,480	32.87	\$182.16	\$5,988.10	\$98,426,300
2012-13 *	2	5,460	31.05	\$181.66	\$5,640.25	\$92,415,500
2012-13 *	3	5,440	30.86	\$181.73	\$5,607.73	\$91,495,600
2012-13 *	4	4,940	28.25	\$182.84	\$5,165.42	\$76,541,200
2012-13 *	TOTAL	5,330	30.82	\$182.07	\$5,611.34	\$358,878,700
2013-14 **	1	5,450	36.88	\$193.32	\$7,129.50	\$116,490,200
2013-14 **	2	5,460	31.62	\$182.97	\$5,785.46	\$94,732,500
2013-14 **	3	5,430	30.94	\$182.54	\$5,647.12	\$91,999,100
2013-14 **	4	5,450	26.98	\$182.63	\$4,927.07	\$80,560,300
2013-14 **	TOTAL	5,450	31.60	\$185.81	\$5,872.24	\$383,782,200
2014-15 **	1	5,480	36.73	\$182.54	\$6,703.71	\$110,258,700
2014-15 **	2	5,480	31.61	\$182.93	\$5,783.32	\$95,034,600
2014-15 **	3	5,450	30.93	\$182.49	\$5,644.90	\$92,291,900
2014-15 **	4	5,470	26.97	\$182.56	\$4,924.45	\$80,804,500
2014-15 **	TOTAL	5,470	31.57	\$182.63	\$5,764.76	\$378,389,700

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of days stay

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MEDICAL TRANSPORTATION**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	46,970	3.13	\$99.09	\$309.95	\$43,674,100
2011-12 *	2	42,390	3.35	\$94.91	\$317.66	\$40,392,500
2011-12 *	3	41,240	3.34	\$93.99	\$313.63	\$38,805,600
2011-12 *	4	36,070	3.36	\$96.28	\$323.74	\$35,029,200
2011-12 *	TOTAL	41,670	3.29	\$96.10	\$315.81	\$157,901,400
2012-13 *	1	38,820	3.65	\$94.09	\$343.39	\$39,991,700
2012-13 *	2	35,740	3.61	\$93.96	\$339.53	\$36,399,500
2012-13 *	3	38,250	3.48	\$93.43	\$324.91	\$37,285,500
2012-13 *	4	34,240	3.31	\$93.64	\$310.31	\$31,878,200
2012-13 *	TOTAL	36,760	3.52	\$93.79	\$329.94	\$145,554,800
2013-14 **	1	40,710	3.87	\$93.99	\$364.18	\$44,473,300
2013-14 **	2	37,500	3.70	\$93.29	\$345.24	\$38,841,000
2013-14 **	3	40,180	3.51	\$92.96	\$326.52	\$39,356,600
2013-14 **	4	36,710	3.40	\$94.11	\$319.68	\$35,210,400
2013-14 **	TOTAL	38,780	3.63	\$93.59	\$339.31	\$157,881,300
2014-15 **	1	42,680	3.95	\$93.75	\$370.38	\$47,423,200
2014-15 **	2	37,580	3.74	\$93.30	\$349.13	\$39,355,700
2014-15 **	3	40,250	3.55	\$92.97	\$330.20	\$39,877,100
2014-15 **	4	36,790	3.44	\$94.18	\$323.72	\$35,731,900
2014-15 **	TOTAL	39,330	3.68	\$93.54	\$344.11	\$162,387,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**OTHER SERVICES**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	211,510	2.88	\$138.04	\$396.96	\$251,875,700
2011-12 *	2	222,590	2.91	\$128.99	\$374.97	\$250,390,900
2011-12 *	3	237,950	2.85	\$121.02	\$344.32	\$245,789,100
2011-12 *	4	236,390	2.96	\$98.49	\$291.41	\$206,653,700
2011-12 *	TOTAL	227,110	2.90	\$120.92	\$350.32	\$954,709,400
2012-13 *	1	217,450	3.16	\$120.97	\$382.24	\$249,358,500
2012-13 *	2	197,550	2.86	\$120.04	\$343.62	\$203,643,600
2012-13 *	3	179,200	3.04	\$100.75	\$306.29	\$164,658,100
2012-13 *	4	207,820	3.48	\$75.65	\$263.55	\$164,314,600
2012-13 *	TOTAL	200,500	3.14	\$103.38	\$325.00	\$781,974,900
2013-14 **	1	206,940	3.41	\$97.14	\$330.94	\$205,454,500
2013-14 **	2	191,510	3.08	\$94.96	\$292.69	\$168,156,100
2013-14 **	3	196,550	3.21	\$89.52	\$287.79	\$169,693,400
2013-14 **	4	202,320	3.44	\$78.54	\$270.05	\$163,908,300
2013-14 **	TOTAL	199,330	3.29	\$89.88	\$295.67	\$707,212,300
2014-15 **	1	207,070	3.65	\$94.48	\$344.66	\$214,100,800
2014-15 **	2	190,770	3.29	\$94.59	\$310.96	\$177,962,200
2014-15 **	3	196,060	3.42	\$89.20	\$305.14	\$179,481,000
2014-15 **	4	201,940	3.64	\$77.96	\$284.02	\$172,066,300
2014-15 **	TOTAL	198,960	3.50	\$88.88	\$311.46	\$743,610,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**HOME HEALTH**

**AVERAGE MONTHLY**

<u>YEAR</u>	<u>QUARTER</u>	<u>USERS</u>	<u>UNITS PER USER</u>	<u>COST PER UNIT</u>	<u>COST PER USER</u>	<u>TOTAL COST</u>
2011-12 *	1	5,460	2.43	\$1,189.78	\$2,892.28	\$47,364,100
2011-12 *	2	5,490	2.56	\$1,186.45	\$3,036.60	\$50,049,300
2011-12 *	3	5,660	2.66	\$1,230.19	\$3,275.06	\$55,581,100
2011-12 *	4	4,990	2.62	\$1,272.76	\$3,340.14	\$50,005,300
2011-12 *	TOTAL	5,400	2.57	\$1,219.49	\$3,132.71	\$202,999,700
2012-13 *	1	5,040	2.99	\$1,339.91	\$3,999.70	\$60,515,500
2012-13 *	2	4,860	2.83	\$1,343.06	\$3,800.03	\$55,457,600
2012-13 *	3	4,990	2.89	\$1,288.04	\$3,719.20	\$55,635,500
2012-13 *	4	4,340	2.88	\$1,299.37	\$3,741.46	\$48,691,300
2012-13 *	TOTAL	4,810	2.90	\$1,318.19	\$3,818.22	\$220,300,000
2013-14 **	1	4,810	3.51	\$1,378.19	\$4,838.47	\$69,750,900
2013-14 **	2	4,660	3.13	\$1,356.43	\$4,244.77	\$59,332,200
2013-14 **	3	4,980	3.13	\$1,282.26	\$4,013.23	\$59,929,700
2013-14 **	4	4,540	3.03	\$1,306.07	\$3,960.27	\$53,907,400
2013-14 **	TOTAL	4,740	3.20	\$1,332.06	\$4,266.35	\$242,920,100
2014-15 **	1	4,850	3.63	\$1,374.45	\$4,986.81	\$72,563,900
2014-15 **	2	4,660	3.32	\$1,363.81	\$4,523.01	\$63,221,200
2014-15 **	3	4,980	3.32	\$1,289.14	\$4,274.60	\$63,832,700
2014-15 **	4	4,540	3.23	\$1,312.59	\$4,238.47	\$57,694,300
2014-15 **	TOTAL	4,760	3.37	\$1,335.84	\$4,508.40	\$257,312,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = Number of claims

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**PA-OAS**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	165,100	4.55	\$121.00	\$550.57	\$272,691,200
2011-12 *	2	163,260	4.62	\$113.83	\$525.64	\$257,451,000
2011-12 *	3	175,300	4.51	\$114.47	\$516.79	\$271,776,600
2011-12 *	4	167,290	4.36	\$114.74	\$500.11	\$250,990,400
2011-12 *	TOTAL	167,740	4.51	\$116.00	\$523.10	\$1,052,909,200
2012-13 *	1	165,160	4.72	\$119.56	\$564.03	\$279,465,200
2012-13 *	2	158,670	4.42	\$121.00	\$535.20	\$254,765,900
2012-13 *	3	156,470	4.32	\$115.55	\$499.57	\$234,508,900
2012-13 *	4	137,400	4.05	\$115.44	\$467.98	\$192,909,900
2012-13 *	TOTAL	154,430	4.39	\$118.09	\$518.93	\$961,649,900
2013-14 **	1	153,950	4.92	\$128.79	\$634.04	\$292,833,700
2013-14 **	2	142,780	4.50	\$116.11	\$522.44	\$223,774,400
2013-14 **	3	151,180	4.47	\$117.15	\$523.87	\$237,600,400
2013-14 **	4	138,250	4.29	\$120.29	\$515.58	\$213,839,800
2013-14 **	TOTAL	146,540	4.55	\$120.90	\$550.50	\$968,048,200
2014-15 **	1	154,100	4.98	\$118.48	\$590.46	\$272,973,800
2014-15 **	2	142,910	4.51	\$116.32	\$524.76	\$224,973,800
2014-15 **	3	151,350	4.48	\$117.34	\$525.93	\$238,792,100
2014-15 **	4	138,420	4.29	\$120.56	\$517.79	\$215,026,800
2014-15 **	TOTAL	146,690	4.58	\$118.13	\$540.67	\$951,766,500

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**PA-AB**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	10,710	7.42	\$154.53	\$1,147.38	\$36,851,500
2011-12 *	2	10,130	7.56	\$154.09	\$1,164.79	\$35,408,600
2011-12 *	3	9,820	7.15	\$156.65	\$1,119.75	\$32,972,100
2011-12 *	4	8,990	6.77	\$161.92	\$1,096.81	\$29,567,800
2011-12 *	TOTAL	9,910	7.24	\$156.50	\$1,133.53	\$134,800,000
2012-13 *	1	8,680	7.38	\$169.01	\$1,247.47	\$32,480,400
2012-13 *	2	8,340	6.90	\$169.47	\$1,168.56	\$29,224,400
2012-13 *	3	8,130	6.82	\$168.12	\$1,145.79	\$27,953,800
2012-13 *	4	7,310	6.55	\$168.52	\$1,103.29	\$24,206,200
2012-13 *	TOTAL	8,120	6.93	\$168.80	\$1,169.25	\$113,864,900
2013-14 **	1	8,080	7.91	\$171.88	\$1,359.29	\$32,930,900
2013-14 **	2	7,560	7.27	\$168.48	\$1,225.01	\$27,765,700
2013-14 **	3	7,720	7.15	\$169.58	\$1,211.82	\$28,076,800
2013-14 **	4	7,180	6.82	\$170.09	\$1,160.53	\$25,014,400
2013-14 **	TOTAL	7,630	7.30	\$170.08	\$1,242.01	\$113,787,900
2014-15 **	1	7,990	8.22	\$171.39	\$1,408.68	\$33,771,700
2014-15 **	2	7,500	7.36	\$174.46	\$1,283.85	\$28,887,600
2014-15 **	3	7,670	7.23	\$175.32	\$1,267.93	\$29,157,800
2014-15 **	4	7,130	6.90	\$175.28	\$1,209.56	\$25,868,000
2014-15 **	TOTAL	7,570	7.45	\$173.96	\$1,295.27	\$117,685,000

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**PA-ATD**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	444,250	6.30	\$162.39	\$1,022.85	\$1,363,193,000
2011-12 *	2	428,150	6.10	\$165.66	\$1,009.91	\$1,297,161,300
2011-12 *	3	415,010	5.69	\$169.99	\$967.21	\$1,204,196,400
2011-12 *	4	385,430	5.20	\$178.18	\$927.10	\$1,071,990,800
2011-12 *	TOTAL	418,210	5.84	\$168.34	\$983.67	\$4,936,541,500
2012-13 *	1	373,210	5.62	\$186.78	\$1,049.80	\$1,175,374,200
2012-13 *	2	363,510	5.34	\$188.91	\$1,008.42	\$1,099,715,800
2012-13 *	3	357,060	5.29	\$188.26	\$996.31	\$1,067,238,700
2012-13 *	4	329,110	5.15	\$182.70	\$941.06	\$929,123,100
2012-13 *	TOTAL	355,720	5.36	\$186.78	\$1,000.65	\$4,271,451,900
2013-14 **	1	366,950	6.08	\$195.71	\$1,190.38	\$1,310,432,600
2013-14 **	2	341,340	5.60	\$195.21	\$1,093.43	\$1,119,683,800
2013-14 **	3	345,810	5.48	\$194.77	\$1,067.88	\$1,107,852,700
2013-14 **	4	325,320	5.27	\$191.78	\$1,010.02	\$985,743,300
2013-14 **	TOTAL	344,860	5.62	\$194.49	\$1,093.14	\$4,523,712,400
2014-15 **	1	360,690	6.35	\$197.44	\$1,253.31	\$1,356,176,900
2014-15 **	2	337,070	5.70	\$201.09	\$1,146.42	\$1,159,281,900
2014-15 **	3	341,410	5.59	\$200.24	\$1,118.67	\$1,145,768,000
2014-15 **	4	320,920	5.37	\$196.33	\$1,054.58	\$1,015,294,800
2014-15 **	TOTAL	340,020	5.77	\$198.77	\$1,146.13	\$4,676,521,600

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**PA-AFDC**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	172,060	2.37	\$149.44	\$354.39	\$182,923,300
2011-12 *	2	185,860	2.42	\$143.92	\$348.89	\$194,537,100
2011-12 *	3	185,220	2.48	\$145.81	\$361.52	\$200,885,000
2011-12 *	4	179,420	2.44	\$145.97	\$355.74	\$191,481,600
2011-12 *	TOTAL	180,640	2.43	\$146.21	\$355.14	\$769,827,000
2012-13 *	1	177,900	2.47	\$153.67	\$380.24	\$202,935,600
2012-13 *	2	183,000	2.42	\$154.03	\$373.33	\$204,955,100
2012-13 *	3	190,210	2.44	\$155.43	\$379.99	\$216,838,600
2012-13 *	4	170,800	2.48	\$148.98	\$368.82	\$188,985,000
2012-13 *	TOTAL	180,480	2.45	\$153.10	\$375.72	\$813,714,400
2013-14 **	1	193,010	2.48	\$163.17	\$403.85	\$233,845,000
2013-14 **	2	186,110	2.36	\$158.08	\$373.69	\$208,648,200
2013-14 **	3	185,940	2.46	\$157.81	\$387.68	\$216,255,700
2013-14 **	4	170,480	2.42	\$151.38	\$366.68	\$187,535,700
2013-14 **	TOTAL	183,890	2.43	\$157.82	\$383.52	\$846,284,600
2014-15 **	1	195,490	2.48	\$165.55	\$411.39	\$241,265,900
2014-15 **	2	182,840	2.39	\$162.67	\$388.76	\$213,245,400
2014-15 **	3	183,600	2.48	\$162.09	\$402.21	\$221,536,000
2014-15 **	4	168,380	2.45	\$155.13	\$380.21	\$192,063,500
2014-15 **	TOTAL	182,580	2.45	\$161.57	\$396.23	\$868,110,800

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**LT-OAS**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	37,150	28.73	\$158.14	\$4,543.37	\$506,358,200
2011-12 *	2	36,650	30.01	\$156.21	\$4,687.49	\$515,403,800
2011-12 *	3	36,540	29.99	\$156.10	\$4,680.94	\$513,092,000
2011-12 *	4	36,030	28.12	\$153.04	\$4,303.12	\$465,081,000
2011-12 *	TOTAL	36,590	29.21	\$155.91	\$4,554.66	\$1,999,935,100
2012-13 *	1	36,600	31.90	\$160.17	\$5,110.25	\$561,069,300
2012-13 *	2	36,710	30.15	\$181.56	\$5,473.60	\$602,823,900
2012-13 *	3	36,150	30.57	\$160.08	\$4,893.15	\$530,691,800
2012-13 *	4	33,100	25.44	\$160.50	\$4,082.97	\$405,381,400
2012-13 *	TOTAL	35,640	29.61	\$165.82	\$4,910.27	\$2,099,966,500
2013-14 **	1	36,240	36.53	\$161.85	\$5,912.84	\$642,829,000
2013-14 **	2	35,520	31.00	\$162.03	\$5,023.59	\$535,245,800
2013-14 **	3	35,410	30.89	\$160.80	\$4,967.60	\$527,748,700
2013-14 **	4	33,900	28.33	\$162.53	\$4,605.26	\$468,321,500
2013-14 **	TOTAL	35,270	31.76	\$161.78	\$5,137.46	\$2,174,145,000
2014-15 **	1	36,270	35.19	\$162.11	\$5,704.08	\$620,611,100
2014-15 **	2	35,510	31.06	\$161.98	\$5,030.84	\$535,994,300
2014-15 **	3	35,420	30.95	\$160.74	\$4,974.40	\$528,508,500
2014-15 **	4	33,900	28.37	\$162.48	\$4,610.12	\$468,827,400
2014-15 **	TOTAL	35,270	31.45	\$161.82	\$5,088.65	\$2,153,941,300

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**LT-AB**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	210	30.66	\$159.68	\$4,894.88	\$3,093,600
2011-12 *	2	210	32.93	\$166.93	\$5,497.25	\$3,507,200
2011-12 *	3	210	32.33	\$161.43	\$5,218.98	\$3,361,000
2011-12 *	4	200	29.52	\$158.88	\$4,689.94	\$2,842,100
2011-12 *	TOTAL	210	31.39	\$161.89	\$5,080.92	\$12,803,900
2012-13 *	1	200	33.07	\$166.61	\$5,509.55	\$3,322,300
2012-13 *	2	200	32.27	\$181.78	\$5,865.50	\$3,484,100
2012-13 *	3	190	31.80	\$165.83	\$5,273.83	\$3,069,400
2012-13 *	4	190	27.48	\$171.34	\$4,708.50	\$2,632,100
2012-13 *	TOTAL	190	31.21	\$171.39	\$5,349.78	\$12,507,800
2013-14 **	1	200	36.27	\$175.58	\$6,368.33	\$3,739,500
2013-14 **	2	190	32.69	\$186.09	\$6,082.89	\$3,553,200
2013-14 **	3	200	31.67	\$183.57	\$5,813.31	\$3,422,500
2013-14 **	4	190	28.37	\$174.19	\$4,942.41	\$2,772,700
2013-14 **	TOTAL	190	32.29	\$179.95	\$5,811.07	\$13,487,900
2014-15 **	1	200	35.78	\$167.71	\$6,001.22	\$3,528,700
2014-15 **	2	200	32.61	\$186.06	\$6,067.18	\$3,553,900
2014-15 **	3	200	31.65	\$183.57	\$5,810.66	\$3,422,600
2014-15 **	4	190	28.34	\$174.17	\$4,935.41	\$2,769,900
2014-15 **	TOTAL	190	32.14	\$177.74	\$5,712.16	\$13,275,100

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**LT-ATD**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	11,470	30.08	\$193.60	\$5,824.37	\$200,457,400
2011-12 *	2	11,390	31.41	\$191.36	\$6,009.97	\$205,444,700
2011-12 *	3	11,370	31.22	\$189.58	\$5,918.17	\$201,857,000
2011-12 *	4	11,370	29.01	\$190.21	\$5,517.94	\$188,205,900
2011-12 *	TOTAL	11,400	30.43	\$191.19	\$5,817.73	\$795,965,000
2012-13 *	1	11,560	32.89	\$193.87	\$6,375.65	\$221,177,700
2012-13 *	2	11,560	31.62	\$213.23	\$6,741.60	\$233,704,200
2012-13 *	3	11,450	31.67	\$197.78	\$6,264.06	\$215,214,100
2012-13 *	4	10,800	26.67	\$202.02	\$5,388.24	\$174,654,500
2012-13 *	TOTAL	11,340	30.78	\$201.63	\$6,205.56	\$844,750,600
2013-14 **	1	11,650	37.04	\$198.35	\$7,346.60	\$256,805,600
2013-14 **	2	11,420	32.29	\$200.50	\$6,473.30	\$221,716,800
2013-14 **	3	11,350	31.93	\$197.93	\$6,319.55	\$215,230,900
2013-14 **	4	11,020	28.81	\$200.61	\$5,778.74	\$191,048,800
2013-14 **	TOTAL	11,360	32.57	\$199.27	\$6,490.38	\$884,802,100
2014-15 **	1	11,700	36.12	\$199.62	\$7,210.82	\$253,080,200
2014-15 **	2	11,410	32.34	\$200.87	\$6,495.99	\$222,329,500
2014-15 **	3	11,340	31.98	\$198.30	\$6,342.62	\$215,839,200
2014-15 **	4	11,010	28.86	\$200.42	\$5,783.12	\$191,030,800
2014-15 **	TOTAL	11,370	32.38	\$199.78	\$6,469.02	\$882,279,700

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MN-OAS**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	96,130	5.10	\$127.71	\$650.97	\$187,725,600
2011-12 *	2	90,490	5.07	\$125.64	\$637.64	\$173,104,500
2011-12 *	3	90,050	4.76	\$123.73	\$589.06	\$159,138,700
2011-12 *	4	81,810	4.49	\$126.43	\$568.02	\$139,413,500
2011-12 *	TOTAL	89,620	4.87	\$125.92	\$613.12	\$659,382,300
2012-13 *	1	80,980	4.79	\$129.92	\$622.80	\$151,310,900
2012-13 *	2	79,640	4.51	\$133.72	\$603.19	\$144,119,300
2012-13 *	3	78,270	4.45	\$129.29	\$575.21	\$135,071,500
2012-13 *	4	70,230	4.20	\$130.51	\$547.75	\$115,407,600
2012-13 *	TOTAL	77,280	4.50	\$130.87	\$588.65	\$545,909,300
2013-14 **	1	82,180	4.92	\$142.28	\$699.67	\$172,492,400
2013-14 **	2	76,180	4.52	\$131.46	\$594.18	\$135,794,500
2013-14 **	3	78,840	4.41	\$130.15	\$573.41	\$135,621,000
2013-14 **	4	73,550	4.26	\$132.57	\$564.45	\$124,548,700
2013-14 **	TOTAL	77,690	4.53	\$134.49	\$609.77	\$568,456,600
2014-15 **	1	84,630	4.91	\$132.03	\$648.51	\$164,646,400
2014-15 **	2	78,760	4.45	\$130.36	\$580.34	\$137,121,100
2014-15 **	3	81,470	4.34	\$129.09	\$560.26	\$136,931,900
2014-15 **	4	76,200	4.18	\$131.42	\$549.62	\$125,640,000
2014-15 **	TOTAL	80,260	4.48	\$130.77	\$585.92	\$564,339,500

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MN-AB**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	350	9.37	\$220.67	\$2,067.81	\$2,187,700
2011-12 *	2	310	8.57	\$183.72	\$1,574.78	\$1,444,100
2011-12 *	3	280	7.42	\$204.57	\$1,517.80	\$1,273,400
2011-12 *	4	240	6.71	\$224.37	\$1,505.04	\$1,061,100
2011-12 *	TOTAL	290	8.16	\$207.68	\$1,695.45	\$5,966,300
2012-13 *	1	220	6.78	\$262.59	\$1,780.50	\$1,200,100
2012-13 *	2	210	6.70	\$244.88	\$1,640.71	\$1,028,700
2012-13 *	3	200	7.80	\$220.41	\$1,719.50	\$1,038,600
2012-13 *	4	210	7.58	\$223.25	\$1,691.90	\$1,079,400
2012-13 *	TOTAL	210	7.20	\$237.30	\$1,709.32	\$4,346,800
2013-14 **	1	250	8.02	\$252.64	\$2,024.99	\$1,492,800
2013-14 **	2	220	7.36	\$258.21	\$1,900.35	\$1,276,200
2013-14 **	3	230	7.27	\$300.01	\$2,179.93	\$1,505,200
2013-14 **	4	230	6.84	\$245.83	\$1,682.11	\$1,173,800
2013-14 **	TOTAL	230	7.38	\$263.91	\$1,947.77	\$5,448,000
2014-15 **	1	270	7.90	\$237.81	\$1,879.00	\$1,501,300
2014-15 **	2	240	7.15	\$254.66	\$1,820.33	\$1,292,700
2014-15 **	3	230	7.19	\$299.86	\$2,155.84	\$1,510,200
2014-15 **	4	230	6.81	\$248.31	\$1,691.39	\$1,183,000
2014-15 **	TOTAL	240	7.28	\$258.95	\$1,886.23	\$5,487,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MN-ATD**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	74,640	6.08	\$229.44	\$1,395.43	\$312,459,500
2011-12 *	2	72,530	5.94	\$222.79	\$1,324.11	\$288,124,600
2011-12 *	3	73,340	5.62	\$222.09	\$1,247.46	\$274,451,800
2011-12 *	4	69,340	5.45	\$233.96	\$1,276.21	\$265,473,700
2011-12 *	TOTAL	72,460	5.78	\$226.94	\$1,311.62	\$1,140,509,600
2012-13 *	1	68,870	5.90	\$257.05	\$1,516.53	\$313,336,400
2012-13 *	2	68,290	5.55	\$260.39	\$1,444.03	\$295,859,100
2012-13 *	3	66,040	5.51	\$257.96	\$1,422.58	\$281,860,700
2012-13 *	4	61,080	5.49	\$243.34	\$1,336.10	\$244,812,800
2012-13 *	TOTAL	66,070	5.62	\$255.03	\$1,432.62	\$1,135,868,900
2013-14 **	1	69,430	6.23	\$257.85	\$1,606.60	\$334,655,200
2013-14 **	2	65,070	5.58	\$269.04	\$1,502.09	\$293,213,200
2013-14 **	3	66,680	5.57	\$261.62	\$1,456.67	\$291,371,800
2013-14 **	4	64,210	5.43	\$254.11	\$1,380.99	\$266,014,900
2013-14 **	TOTAL	66,350	5.71	\$260.60	\$1,488.72	\$1,185,255,100
2014-15 **	1	72,280	6.41	\$259.26	\$1,662.20	\$360,435,700
2014-15 **	2	68,290	5.58	\$268.28	\$1,497.45	\$306,769,800
2014-15 **	3	70,020	5.56	\$260.92	\$1,451.21	\$304,823,100
2014-15 **	4	67,600	5.42	\$252.89	\$1,370.51	\$277,957,900
2014-15 **	TOTAL	69,550	5.75	\$260.35	\$1,497.77	\$1,249,986,500

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MN-AFDC**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	426,890	2.75	\$181.62	\$499.36	\$639,509,400
2011-12 *	2	451,290	2.76	\$178.02	\$492.19	\$666,363,200
2011-12 *	3	450,720	2.83	\$176.51	\$498.85	\$674,527,200
2011-12 *	4	451,810	2.76	\$176.71	\$487.91	\$661,319,500
2011-12 *	TOTAL	445,180	2.78	\$178.16	\$494.51	\$2,641,719,300
2012-13 *	1	468,560	2.85	\$185.24	\$527.33	\$741,246,400
2012-13 *	2	472,110	2.73	\$185.65	\$507.26	\$718,454,600
2012-13 *	3	484,110	2.73	\$184.67	\$503.63	\$731,445,800
2012-13 *	4	439,000	2.71	\$176.73	\$478.21	\$629,810,300
2012-13 *	TOTAL	465,950	2.75	\$183.23	\$504.52	\$2,820,957,100
2013-14 **	1	511,200	2.84	\$187.81	\$532.48	\$816,619,900
2013-14 **	2	471,340	2.73	\$186.97	\$509.51	\$720,457,100
2013-14 **	3	474,100	2.75	\$184.13	\$507.03	\$721,158,800
2013-14 **	4	443,330	2.66	\$178.18	\$473.92	\$630,304,800
2013-14 **	TOTAL	475,000	2.75	\$184.51	\$506.77	\$2,888,540,600
2014-15 **	1	512,560	2.88	\$188.86	\$544.16	\$836,733,500
2014-15 **	2	468,430	2.74	\$189.24	\$518.36	\$728,441,300
2014-15 **	3	471,170	2.77	\$186.31	\$515.85	\$729,154,200
2014-15 **	4	440,390	2.68	\$179.91	\$481.57	\$636,234,000
2014-15 **	TOTAL	473,140	2.77	\$186.31	\$516.16	\$2,930,563,000

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MI-C**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	80,880	2.47	\$133.16	\$329.43	\$79,937,300
2011-12 *	2	79,190	2.63	\$136.70	\$358.98	\$85,283,500
2011-12 *	3	75,280	2.73	\$136.02	\$371.76	\$83,959,600
2011-12 *	4	71,370	2.66	\$135.13	\$359.07	\$76,874,900
2011-12 *	TOTAL	76,680	2.62	\$135.27	\$354.34	\$326,055,200
2012-13 *	1	77,770	2.67	\$147.82	\$395.02	\$92,161,500
2012-13 *	2	76,460	2.64	\$149.40	\$393.68	\$90,299,200
2012-13 *	3	78,210	2.74	\$153.28	\$419.62	\$98,452,200
2012-13 *	4	69,810	2.67	\$146.88	\$392.88	\$82,286,000
2012-13 *	TOTAL	75,560	2.68	\$149.44	\$400.55	\$363,198,900
2013-14 **	1	85,540	2.68	\$147.55	\$395.23	\$101,421,500
2013-14 **	2	76,680	2.71	\$151.96	\$412.10	\$94,803,500
2013-14 **	3	75,930	2.80	\$151.79	\$425.34	\$96,895,000
2013-14 **	4	69,470	2.65	\$149.73	\$397.10	\$82,756,500
2013-14 **	TOTAL	76,910	2.71	\$150.21	\$407.29	\$375,876,500
2014-15 **	1	85,390	2.73	\$152.17	\$415.22	\$106,363,500
2014-15 **	2	76,260	2.74	\$154.50	\$423.47	\$96,877,100
2014-15 **	3	75,590	2.83	\$154.48	\$437.10	\$99,121,800
2014-15 **	4	69,200	2.68	\$151.56	\$406.58	\$84,410,800
2014-15 **	TOTAL	76,610	2.75	\$153.20	\$420.72	\$386,773,100

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**MI-A**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	1,460	12.68	\$207.77	\$2,634.34	\$11,543,700
2011-12 *	2	1,400	14.53	\$190.19	\$2,763.11	\$11,605,100
2011-12 *	3	1,370	14.34	\$199.33	\$2,858.92	\$11,773,000
2011-12 *	4	1,440	13.81	\$193.03	\$2,665.85	\$11,479,100
2011-12 *	TOTAL	1,420	13.83	\$197.36	\$2,728.50	\$46,400,900
2012-13 *	1	1,570	13.43	\$200.08	\$2,687.45	\$12,631,000
2012-13 *	2	1,610	10.46	\$194.65	\$2,036.06	\$9,824,000
2012-13 *	3	1,620	14.16	\$217.14	\$3,074.53	\$14,948,400
2012-13 *	4	1,470	12.29	\$198.60	\$2,441.55	\$10,755,000
2012-13 *	TOTAL	1,570	12.59	\$203.55	\$2,562.71	\$48,158,400
2013-14 **	1	1,820	15.31	\$199.23	\$3,051.00	\$16,687,600
2013-14 **	2	1,610	14.40	\$198.00	\$2,850.19	\$13,749,400
2013-14 **	3	1,580	14.05	\$204.87	\$2,879.33	\$13,673,100
2013-14 **	4	1,560	13.17	\$197.14	\$2,596.63	\$12,159,600
2013-14 **	TOTAL	1,640	14.28	\$199.80	\$2,852.69	\$56,269,600
2014-15 **	1	1,880	14.06	\$198.95	\$2,798.04	\$15,780,700
2014-15 **	2	1,630	14.31	\$197.46	\$2,825.13	\$13,782,400
2014-15 **	3	1,590	14.03	\$204.57	\$2,870.16	\$13,691,200
2014-15 **	4	1,560	13.25	\$196.84	\$2,607.57	\$12,231,900
2014-15 **	TOTAL	1,660	13.92	\$199.46	\$2,777.15	\$55,486,100

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**REFUGEE**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	630	2.95	\$86.23	\$254.12	\$479,500
2011-12 *	2	670	2.86	\$96.08	\$274.48	\$549,800
2011-12 *	3	550	2.62	\$108.65	\$284.88	\$469,500
2011-12 *	4	480	2.80	\$110.76	\$310.22	\$443,600
2011-12 *	TOTAL	580	2.81	\$99.06	\$278.76	\$1,942,400
2012-13 *	1	550	2.90	\$111.14	\$322.31	\$528,900
2012-13 *	2	730	2.91	\$135.51	\$395.01	\$859,200
2012-13 *	3	860	2.63	\$125.90	\$330.86	\$855,600
2012-13 *	4	720	2.78	\$122.81	\$341.07	\$740,800
2012-13 *	TOTAL	710	2.79	\$124.73	\$348.08	\$2,984,500
2013-14 **	1	850	2.76	\$200.44	\$553.53	\$1,405,900
2013-14 **	2	580	3.22	\$133.53	\$429.42	\$747,800
2013-14 **	3	800	2.52	\$126.54	\$318.48	\$760,500
2013-14 **	4	630	2.65	\$139.78	\$370.98	\$704,200
2013-14 **	TOTAL	710	2.76	\$152.92	\$422.34	\$3,618,400
2014-15 **	1	770	2.81	\$122.32	\$343.37	\$791,200
2014-15 **	2	790	3.15	\$126.84	\$398.97	\$942,200
2014-15 **	3	1,030	2.55	\$120.88	\$307.76	\$948,300
2014-15 **	4	790	2.62	\$132.75	\$347.29	\$818,100
2014-15 **	TOTAL	840	2.76	\$125.42	\$346.42	\$3,499,800

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**OBRA**

**AVERAGE MONTHLY**

<b>YEAR</b>	<b>QUARTER</b>	<b>USERS</b>	<b>UNITS PER USER</b>	<b>COST PER UNIT</b>	<b>COST PER USER</b>	<b>TOTAL COST</b>
2011-12 *	1	15,190	4.99	\$264.04	\$1,317.08	\$60,011,500
2011-12 *	2	15,220	5.32	\$262.20	\$1,395.49	\$63,697,200
2011-12 *	3	14,990	5.42	\$248.66	\$1,348.04	\$60,602,400
2011-12 *	4	14,440	5.16	\$255.75	\$1,320.34	\$57,187,700
2011-12 *	TOTAL	14,960	5.22	\$257.58	\$1,345.56	\$241,498,700
2012-13 *	1	15,370	5.50	\$272.70	\$1,500.62	\$69,184,600
2012-13 *	2	15,250	5.31	\$287.60	\$1,527.93	\$69,910,600
2012-13 *	3	14,840	5.32	\$260.99	\$1,389.10	\$61,846,900
2012-13 *	4	13,090	5.03	\$268.16	\$1,347.65	\$52,918,100
2012-13 *	TOTAL	14,640	5.30	\$272.65	\$1,445.27	\$253,860,300
2013-14 **	1	15,870	5.70	\$246.90	\$1,406.69	\$66,962,100
2013-14 **	2	13,640	5.77	\$260.62	\$1,504.65	\$61,567,400
2013-14 **	3	13,700	5.66	\$260.25	\$1,471.78	\$60,501,100
2013-14 **	4	12,890	5.25	\$261.15	\$1,370.71	\$53,018,900
2013-14 **	TOTAL	14,030	5.60	\$256.69	\$1,438.13	\$242,049,500
2014-15 **	1	15,900	5.74	\$257.74	\$1,479.43	\$70,580,900
2014-15 **	2	13,620	5.90	\$263.65	\$1,556.23	\$63,581,600
2014-15 **	3	13,700	5.78	\$263.28	\$1,520.78	\$62,493,500
2014-15 **	4	12,890	5.36	\$262.92	\$1,410.28	\$54,539,800
2014-15 **	TOTAL	14,030	5.70	\$261.71	\$1,492.28	\$251,195,800

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**POV 185**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	126,390	3.18	\$174.30	\$554.01	\$210,062,500
2011-12 *	2	123,020	3.28	\$188.00	\$617.27	\$227,799,200
2011-12 *	3	124,150	3.33	\$186.32	\$620.14	\$230,978,500
2011-12 *	4	120,650	3.17	\$178.04	\$564.40	\$204,285,200
2011-12 *	TOTAL	123,550	3.24	\$181.75	\$588.90	\$873,125,400
2012-13 *	1	125,790	3.40	\$186.02	\$633.28	\$238,970,900
2012-13 *	2	123,760	3.36	\$192.40	\$646.57	\$240,058,700
2012-13 *	3	129,140	3.31	\$192.14	\$635.44	\$246,188,900
2012-13 *	4	113,550	3.14	\$193.33	\$606.33	\$206,542,400
2012-13 *	TOTAL	123,060	3.31	\$190.86	\$630.97	\$931,760,800
2013-14 **	1	140,920	3.44	\$187.90	\$646.90	\$273,488,300
2013-14 **	2	126,270	3.35	\$197.14	\$659.53	\$249,842,100
2013-14 **	3	131,880	3.30	\$193.46	\$637.54	\$252,236,800
2013-14 **	4	124,480	3.08	\$184.50	\$567.49	\$211,920,300
2013-14 **	TOTAL	130,890	3.29	\$190.81	\$628.71	\$987,487,600
2014-15 **	1	150,370	3.43	\$185.41	\$635.82	\$286,817,700
2014-15 **	2	131,720	3.34	\$194.13	\$647.72	\$255,960,700
2014-15 **	3	137,100	3.29	\$190.76	\$627.65	\$258,155,300
2014-15 **	4	129,570	3.08	\$181.72	\$559.06	\$217,308,500
2014-15 **	TOTAL	137,190	3.29	\$188.05	\$618.51	\$1,018,242,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**POV 133**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	16,060	1.93	\$131.65	\$253.98	\$12,237,800
2011-12 *	2	18,070	2.02	\$122.47	\$247.04	\$13,388,300
2011-12 *	3	18,230	2.11	\$117.36	\$247.06	\$13,508,500
2011-12 *	4	18,080	2.04	\$122.40	\$249.81	\$13,546,500
2011-12 *	TOTAL	17,610	2.03	\$123.07	\$249.34	\$52,681,100
2012-13 *	1	18,260	2.02	\$133.83	\$269.86	\$14,779,700
2012-13 *	2	19,250	1.97	\$128.56	\$253.86	\$14,663,800
2012-13 *	3	20,610	2.04	\$124.32	\$253.28	\$15,664,000
2012-13 *	4	18,910	2.10	\$121.97	\$255.56	\$14,495,600
2012-13 *	TOTAL	19,260	2.03	\$126.99	\$257.92	\$59,603,200
2013-14 **	1	21,510	1.99	\$133.77	\$266.69	\$17,212,000
2013-14 **	2	20,660	1.96	\$124.01	\$243.12	\$15,071,800
2013-14 **	3	20,890	2.07	\$126.36	\$262.08	\$16,426,200
2013-14 **	4	18,920	2.03	\$121.26	\$246.18	\$13,974,300
2013-14 **	TOTAL	20,500	2.01	\$126.52	\$254.84	\$62,684,300
2014-15 **	1	21,780	2.01	\$129.91	\$261.02	\$17,055,500
2014-15 **	2	20,530	1.97	\$125.34	\$246.66	\$15,191,900
2014-15 **	3	20,760	2.09	\$127.73	\$266.35	\$16,585,700
2014-15 **	4	18,840	2.04	\$122.34	\$249.47	\$14,101,100
2014-15 **	TOTAL	20,480	2.03	\$126.47	\$256.11	\$62,934,200

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

**QUARTERLY SUMMARY  
OF  
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY  
(INCLUDES ACTUALS AND NOVEMBER 2013 BASE ESTIMATES)**

**POV 100**

YEAR	QUARTER	AVERAGE MONTHLY				TOTAL COST
		USERS	UNITS PER USER	COST PER UNIT	COST PER USER	
2011-12 *	1	14,820	2.29	\$156.78	\$358.92	\$15,961,000
2011-12 *	2	15,870	2.31	\$151.29	\$348.86	\$16,610,100
2011-12 *	3	15,890	2.37	\$135.42	\$320.57	\$15,282,500
2011-12 *	4	16,310	2.39	\$126.48	\$302.25	\$14,785,800
2011-12 *	TOTAL	15,720	2.34	\$141.93	\$332.00	\$62,639,400
2012-13 *	1	17,110	2.32	\$150.16	\$347.76	\$17,847,500
2012-13 *	2	17,630	2.29	\$152.40	\$349.72	\$18,498,900
2012-13 *	3	18,410	2.31	\$156.47	\$361.82	\$19,985,900
2012-13 *	4	18,250	2.41	\$133.40	\$321.58	\$17,606,000
2012-13 *	TOTAL	17,850	2.33	\$147.89	\$345.18	\$73,938,400
2013-14 **	1	21,470	2.36	\$153.89	\$363.43	\$23,411,300
2013-14 **	2	19,290	2.31	\$161.36	\$372.76	\$21,566,500
2013-14 **	3	19,210	2.38	\$156.56	\$372.60	\$21,475,600
2013-14 **	4	18,130	2.41	\$143.32	\$345.68	\$18,796,600
2013-14 **	TOTAL	19,520	2.37	\$153.85	\$363.87	\$85,250,100
2014-15 **	1	21,210	2.43	\$164.00	\$398.96	\$25,382,700
2014-15 **	2	19,080	2.31	\$170.90	\$394.77	\$22,597,600
2014-15 **	3	18,910	2.38	\$166.64	\$397.28	\$22,537,600
2014-15 **	4	17,810	2.42	\$152.31	\$367.95	\$19,662,900
2014-15 **	TOTAL	19,250	2.39	\$163.57	\$390.34	\$90,180,900

\* ACTUAL

\*\* ESTIMATED

NOTE: UNITS = combination of claims, prescription, and days stay (use for comparative purposes only.)

### **Medi-Cal Base Policy Changes**

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

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

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

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

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

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

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

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	GRAND TOTAL	<u>\$22,774,586,000</u>	<u>\$13,458,950,200</u>	<u>\$9,315,635,800</u>

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

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

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	<b>GRAND TOTAL</b>	<b><u>\$23,758,925,000</u></b>	<b><u>\$14,080,605,050</u></b>	<b><u>\$9,678,319,950</u></b>

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

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

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

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

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

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

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

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

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>OTHER</b>						
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$145,524,000	\$0	\$154,922,000	\$0	\$9,398,000	\$0
180	MEDI-CAL TCM PROGRAM	\$45,290,000	\$0	\$44,554,000	\$0	-\$736,000	\$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$37,199,000	\$18,599,500	\$37,899,000	\$18,949,500	\$700,000	\$350,000
182	EPSDT SCREENS	\$38,733,000	\$19,222,200	\$39,279,000	\$19,493,250	\$546,000	\$271,050
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,446,000	\$1,223,000	\$2,571,000	\$1,285,500	\$125,000	\$62,500
189	LAWSUITS/CLAIMS	\$2,496,000	\$1,248,000	\$1,865,000	\$932,500	-\$631,000	-\$315,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,799,000	\$0	\$1,285,000	\$0	-\$514,000	\$0
202	BASE RECOVERIES	-\$262,270,000	-\$132,011,000	-\$255,248,000	-\$128,477,000	\$7,022,000	\$3,534,000
	<b>OTHER SUBTOTAL</b>	<b>\$8,737,020,000</b>	<b>\$2,985,515,800</b>	<b>\$9,047,705,000</b>	<b>\$3,047,195,350</b>	<b>\$310,685,000</b>	<b>\$61,679,550</b>
	<b>GRAND TOTAL</b>	<b>\$22,774,586,000</b>	<b>\$9,315,635,800</b>	<b>\$23,758,925,000</b>	<b>\$9,678,319,950</b>	<b>\$984,339,000</b>	<b>\$362,684,150</b>

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

## MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>DRUG MEDI-CAL</u></b>	
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63	RESIDENTIAL TREATMENT SERVICES
64	OUTPATIENT DRUG FREE TREATMENT SERVICES
65	INTENSIVE OUTPATIENT SERVICES
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM
<b><u>MENTAL HEALTH</u></b>	
69	SMHS FOR CHILDREN
70	SMHS FOR ADULTS
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114	TWO PLAN MODEL
115	COUNTY ORGANIZED HEALTH SYSTEMS
116	GEOGRAPHIC MANAGED CARE
122	PACE (Other M/C)
125	DENTAL MANAGED CARE (Other M/C)
126	SENIOR CARE ACTION NETWORK (Other M/C)
129	AIDS HEALTHCARE CENTERS (Other M/C)
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
<b><u>OTHER</u></b>	
171	PERSONAL CARE SERVICES (Misc. Svcs.)
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
173	MEDICARE PAYMENTS - PART D PHASED-DOWN
174	HOME & COMMUNITY BASED SVCS.-CDDS (Misc.)
175	DENTAL SERVICES
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
180	MEDI-CAL TCM PROGRAM
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
182	EPSDT SCREENS
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
189	LAWSUITS/CLAIMS
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

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

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

## NARCOTIC TREATMENT PROGRAM

**BASE POLICY CHANGE NUMBER:** 62  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1728

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(14); 51341.1 (d)(1); 51516.1 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

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

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

## NARCOTIC TREATMENT PROGRAM

### BASE POLICY CHANGE NUMBER: 62

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

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

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

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

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

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

#### **Methodology:**

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for DMC beginning January 2014. Additional caseload data for the expanded eligibles was developed for mandatory and optional populations expected to access this service in January 2014.
5. Assume the caseload projection for the optional expansion population is 1,163 for FY 2013-14 and 2,739 for FY 2014-15.
6. Assume the caseload projection for the mandatory expansion population is 164 for FY 2013-14 and 642 for FY 2014-15.
7. The Units of Service (UOS) is based on the most recent complete data, July 2011-June 2012 to calculate an average UOS.
8. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by Department of Finance, whichever is lower. FY

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

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

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

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

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

**FY 2013-14**

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

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

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

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

**FY 2014-15**

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

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

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

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

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

**NARCOTIC TREATMENT PROGRAM**

BASE POLICY CHANGE NUMBER: 62

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

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

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

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

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

**Funding:**

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

100% Title XIX (4260-101-0890)

## RESIDENTIAL TREATMENT SERVICES

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

Supervision and treatment services are available day and night, seven days a week. The service provides a range of activities:

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

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

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

## RESIDENTIAL TREATMENT SERVICES

### BASE POLICY CHANGE NUMBER: 63

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

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

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

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

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

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

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

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

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

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

## RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 63

### Methodology:

1. The DMC eligible clients are categorized into Regular and Perinatal.
2. DMC program administration assumes the federal Centers for Medicare and Medicaid Services (CMS) will approve its request to use the existing Perinatal Residential reimbursement rate for both the Perinatal and Non-Perinatal Residential services until FY 2017-18 when FY 2013-14 cost data will be available to produce a new cost-driven non-Perinatal residential rate.
3. The caseload projections are based on 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for DMC beginning January 2014. Additional caseload data was developed for the expanded, mandatory, and optional populations expected to access this service in January 2014.
5. Assume the caseload projection for the expanded population is 9,905 for FY 2013-14 (based on 6 months, January through June 2014) and 19,810 for FY 2014-15.
6. Assume the caseload projection for the mandatory expansion population is 262 for FY 2013-14 (based on 6 months, January through June 2014) and 1,026 for FY 2014-15.
7. Assume the caseload projection for the optional expansion population is 1,860 for FY 2013-14 (based on 6 months, January through June 2014) and 4,379 for FY 2014-15.
8. The Units of Service (UOS) is based on the most recent complete data, July 2011-June 2012 to calculate an average UOS for existing caseload.
9. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

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

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

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

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

**RESIDENTIAL TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 63

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

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

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

**RESIDENTIAL TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 63

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

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

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

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

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

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

**Funding:**

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

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

100% Title XIX (4260-101-0890)

## OUTPATIENT DRUG FREE TREATMENT SERVICES

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Title 22, California Code of Regulations 51341.1 (b)(15); 51341.1 (d)(2); 51516.1 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

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

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

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

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

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

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

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

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

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

### **Methodology:**

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

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

6. Assume the caseload projection for the mandatory expansion population is 396 for FY 2013-14 and 1,549 for FY 2014-15.
7. The Units of Service (UOS) data is based on the most recent complete data, July 2011-June 2012, to calculate an average UOS.
8. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by DOF, whichever is lower. FY 2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 required rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

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

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

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

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

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

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

**OUTPATIENT DRUG FREE TREATMENT SERVICES****BASE POLICY CHANGE NUMBER: 64**

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

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

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

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

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

**OUTPATIENT DRUG FREE TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 64

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

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

**Funding:**

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

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

## INTENSIVE OUTPATIENT SERVICES

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Day Care Rehabilitative IOT services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include:

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

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

## INTENSIVE OUTPATIENT SERVICES

BASE POLICY CHANGE NUMBER: 65

(EPSDT), pregnant and postpartum women.

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

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

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

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

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

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

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

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

### **Methodology:**

1. The DMC eligible clients are categorized into three groups: Regular, EPSDT, and Perinatal.
2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
3. The caseload projections are based on the 36 months of the most recent complete caseload data, January 2010 through December 2012.
4. Due to the ACA, the expansion of Medi-Cal eligibility will impact the caseload and projections for

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

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

5. Assume the caseload projection for the expansion population is 11,929 for FY 2013-14 (based on six months January 2014-July 2014) and 23,858 for FY 2014-15.
6. Assume mandatory expansion population is 317 for FY 2013-14 and 1,238 for FY 2014-15.
7. Assume optional expansion population is 2,243 for FY 2013-14 and 5,282 for FY 2014-15.
8. The Units of Service (UOS) is based on the most recent complete data, July 2011-June 2012 to calculate an average UOS.
9. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2013-14 and FY 2014-15 budgeted amounts are based on the FY 2013-14 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

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

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

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

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

**INTENSIVE OUTPATIENT SERVICES**

BASE POLICY CHANGE NUMBER: 65

<b>Optional</b>				
Regular & EPSDT	2,107	29.4	\$62.15	\$3,849,931
Minor Consent	6	21.6	\$62.15	\$8,055
Perinatal	130	21.6	\$79.39	\$222,927
Total				\$4,080,913
<b>FY 2014-15</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rates</b>	<b>Total</b>
<b>Current</b>				
Regular & EPSDT	14,986	29.4	\$62.15	\$27,382,569
Perinatal	646	21.6	\$79.39	\$1,107,776
Total				\$28,490,345
<b>Expanded</b>				
Regular & EPSDT	22,416	29.4	\$62.15	\$40,958,739
Minor Consent	66	21.6	\$62.15	\$88,601
Perinatal	1,376	21.6	\$79.39	\$2,359,598
Total				\$43,406,938
<b>Mandatory*</b>				
Regular & EPSDT	1,164	29.4	\$62.15	\$2,126,872
Minor Consent	4	21.6	\$62.15	\$5,370
Perinatal	70	21.6	\$79.39	\$120,038
Total				\$2,252,280
<b>Optional</b>				
Regular & EPSDT	4,963	29.4	\$62.15	\$9,068,443
Minor Consent	15	21.6	\$62.15	\$20,137
Perinatal	304	21.6	\$79.39	\$521,306
Total				\$9,609,886

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

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

**INTENSIVE OUTPATIENT SERVICES**

BASE POLICY CHANGE NUMBER: 65

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

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

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

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

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

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

**Funding:**

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

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

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

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

## SMHS FOR CHILDREN

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

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

## SMHS FOR CHILDREN

### BASE POLICY CHANGE NUMBER: 69

The following Medi-Cal SMHS are available for children:

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

\*Children - Age 18 through 20

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

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

#### **Methodology:**

1. The costs are developed using 69 months of Short-Doyle/Medi-Cal (SD/MC) and 67 months Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2013, with dates of service from July 2007 through March 2013. The FFS data is current as of August 23, 2013, with dates of service from July 2007 through January 2013.
2. Due to the lag in reporting of claims data, the most recent six months of data must be weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

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

## SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 69

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

(Dollars In Thousands)

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

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

(Dollars In Thousands)

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

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

(Dollars In Thousands)

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

8. Medicaid Expansion Children's Health Insurance Program (M-CHIP) claims are eligible for federal reimbursement of 65%. Medi-Cal (MC) claims are eligible for 50% federal reimbursement.

(Dollars In Thousands)

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

### Funding:

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

## SMHS FOR ADULTS

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

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

### DESCRIPTION

**Purpose:**

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

**Authority**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

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

## SMHS FOR ADULTS

### BASE POLICY CHANGE NUMBER: 70

The following Medi-Cal SMHS are available for adults:

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

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

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

#### **Methodology:**

1. The costs are developed using 69 months of Short-Doyle/Medi-Cal (SD/MC) and 67 months of Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2013, with dates of service from July 2007 through March 2013. The FFS data is current as of August 23, 2013, with dates of service from July 2007 through January 2013.
2. Due to the lag in reporting of claims data, the six most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

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

## SMHS FOR ADULTS

### BASE POLICY CHANGE NUMBER: 70

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

(Dollars In Thousands)

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

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

(Dollars In Thousands)

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

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

(Dollars In Thousands)

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

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

(Dollars In Thousands)

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

#### Funding:

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

## TWO PLAN MODEL

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

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

### DESCRIPTION

#### **Purpose**

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

#### **Authority:**

Welfare & Institutions Code 14087.3

#### **Interdependent Policy Changes:**

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

#### **Background:**

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

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

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

#### **Methodology:**

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

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

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.
3. The FY 2013-14 and FY 2014-15 rates include:
  - Annual rate redeterminations for FY 2013-14 and FY 2014-15.
  - LTC rate adjustments
  - Hospice rate increase
  - Elimination of inpatient hospital provider payment reduction
  - Inclusion of GHPP services
  - CBAS/Enhancement case management
  - Medicare improvements for Patients and Providers Act
  - Diagnosis related groups
4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through June 30, 2012. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
5. Capitation rate increases due to the Gross Premium Tax and the MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to General Fund, the Extend Gross Premium Tax – Funding Adjustment, and the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
6. The Department receives federal reimbursement of 90% for family planning services.

(Dollars in Thousands)

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

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

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

**Funding:**

(in Thousands)

**FY 2013-14:**

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

**FY 2014-15:**

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

## COUNTY ORGANIZED HEALTH SYSTEMS

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 142 Discontinue Undocumented Beneficiaries from PHC  
 PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 MCO Tax Managed Care Plans

**Background:**

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

COHS expanded into eight counties effective September 1, 2013. These counties include Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Additional information can be found in the Managed Care Expansion to Rural Counties Policy Change.

**Reason for Change from Prior Estimate:**

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

## COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 115

### Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.
2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range.
3. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA). PHC is negotiating with the Department to remove OBRA beneficiaries from their contract effective January 1, 2013.
4. The FY 2013-14 and FY 2014-15 rates include:
  - Annual rate redeterminations for FY 2013-14 and FY 2014-15.
  - LTC rate adjustments
  - Hospice rate increase
  - Elimination of inpatient hospital provider payment reduction
  - CBAS/Enhancement case management
  - Medicare improvements for Patients and Providers Act
  - Elimination of retroactive payments
  - Diagnosis related groups
5. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through June 30, 2012. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
6. The FY 2013-14 impact of the increase in capitation payments related to the Gross Premium Tax is included in the Increase in Capitation Rates for MCO Tax policy change. For additional information on the Gross Premium Tax extension, see the Extend Gross Premium Tax – Incr. Capitation Rates and the Extend Gross Premium Tax – Funding Adjustment policy changes.
7. Capitation rate increases due to the Gross Premium Tax and MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax/Sales tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to General Fund and MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 115

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

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

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

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 115

**Funding: (In Thousands)****FY 2013-14:**

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

**FY 2014-15:**

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

## GEOGRAPHIC MANAGED CARE

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

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

**Background:**

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

**Reason for Change from Prior Estimate:**

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

**Methodology:**

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

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

3. The FY 2013-14 and FY 2014-15 rates include:
  - Annual rate redeterminations for FY 2013-14 and FY 2014-15.
  - LTC rate adjustments
  - Hospice rate increase
  - Elimination of inpatient hospital provider payment reduction
  - CBAS/Enhancement Case Management
  - Medicare improvements for Patients and Providers Act
  - Diagnosis related groups
4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the Gross Premium Tax through June 30, 2012. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
5. Capitation rate increases due to the Gross Premium Tax and MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the Extend Gross Premium Tax – Funding Adjustment and the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
6. The FY 2013-14 and FY 2014-15 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

(Dollars in Thousands)

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

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

**Funding:**

(Rounded in Thousands)

**FY 2013-14:**

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

**GEOGRAPHIC MANAGED CARE**

BASE POLICY CHANGE NUMBER: 116

**FY 2014-15:**

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

## PACE (Other M/C)

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

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

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

Below is a list of PACE organizations:

<u>PACE Organization</u>	<u>County</u>	<u>Operational</u>
On Lok Lifeways	San Francisco Alameda Santa Clara	November 1, 1983 July 1, 2002 January 1, 2009
Centers for Elders' Independence	Alameda	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	December 1, 2013
Central Valley Medical Svcs.	Fresno	January 1, 2014
Redwood Coast	Humboldt	May 1, 2014

**Methodology:**

1. Assume the 2013 and 2014 rates are calculated using the UPL for each year. The 2015 rates will be calculated using the existing comparable population UPL methodology.
2. FY 2013-14 and FY 2014-15 estimated funding is based on calendar year 2013 proposed rates.
3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan and anticipated impact of the CCI demonstration.
4. The Department is working with PACE organizations and proposing changes to current law to transition from a UPL-based methodology to an actuarially sound experienced-based methodology. The Department anticipates restructuring the methodology to determine the rates beginning in January 2015.

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

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

**Funding:**

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

## DENTAL MANAGED CARE (Other M/C)

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$49,050,000	\$49,710,000
- STATE FUNDS	\$24,525,000	\$24,855,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$49,050,000	\$49,710,000
STATE FUNDS	\$24,525,000	\$24,855,000
FEDERAL FUNDS	\$24,525,000	\$24,855,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Social Security Act, Title XIX

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

The changes are due to updated monthly eligibles.

**Methodology:**

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.
2. The retroactive adjustments of the rates from January 2012 to December 2012 are shown in the Dental Retroactive Rate Changes policy change.

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

BASE POLICY CHANGE NUMBER: 125

3. Dental rates for the Senior Care Action Network (SCAN) and the Program of All-Inclusive Care for the Elderly (PACE) are incorporated into the SCAN and PACE policy changes.
4. No rate adjustments have been included for FY 2013-14. The prior period rates have been used.

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

**Funding:**

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

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

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14200

**Interdependent Policy Changes:**

PC 141 SCAN Transition to Managed Care  
 PC 137 Extend Gross Premium Tax  
 PC 159 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 121 Extend Gross Premium Tax – Funding Adjustment  
 PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 MCO Tax Managed Care Plans

**Background:**

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

The Department does not plan to renew the SCAN contract. A one-year contract extension for the period of January 1, 2014 through December 31, 2014 has been executed to facilitate transition of SCAN Medi-Cal population to existing Medi-Cal programs. The SCAN Transition to Managed Care policy change budgets the costs associated with the transition of SCAN population into managed care plans.

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

BASE POLICY CHANGE NUMBER: 126

### Reason for Change from Prior Estimate:

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

### Methodology:

1. Estimated SCAN costs are computed by multiplying the actual and estimated monthly eligible count for each county times the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.
2. Total enrollment is projected to be 8,072 in June 2014 and 8,167 by December 2014 based on Medi-Cal eligibles data submitted by SCAN.
3. The 2012 and 2013 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for 2014 have not been finalized. Therefore, FY 2013-14 and FY 2014-15 rates are based on preliminary rates. Rates in development will be based on SCAN plans' actual experience.
4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the Gross Premium Tax through June 30, 2012. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.
5. The Department received final CMS approval of SCAN 2010-11 rates in August 2013. This will result in a repayment to SCAN of approximately \$8,700,000 for the increase of 2010 Aged/Disabled rates that were paid at 2009 capitated rates. The Department will also recoup approximately \$17,300,000 for decrease to the 2010 Long-Term Care rates that were paid at 2009 capitated rates. Both the repayment and recoupment will occur in FY 2013-14.
6. The Department received final CMS approval of SCAN 2012-13 rates in August 2013. Subsequently, the Department will repay SCAN approximately \$10,700,000 for capitation payments made using SCAN 2009 rates for period of January 2012 through September 2013; the repayment will occur in FY 2013-14.
7. Assume SCAN participants will transition out of SCAN into Coordinated Care Initiative managed care plans beginning January 1, 2015. This transition is shown in the SCAN Transition to Managed Care policy change.

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

BASE POLICY CHANGE NUMBER: 126

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

**Funding:**

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

## AIDS HEALTHCARE CENTERS (Other M/C)

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14088.85

**Interdependent Policy Changes:**

PC 137 Extend Gross Premium Tax  
 PC 159 Extend Gross Premium Tax – Incr. Capitation Rates  
 PC 121 Extend Gross Premium Tax – Funding Adjustment  
 PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment  
 PC 140 MCO Tax Managed Care Plans

**Background:**

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with AIDS Healthcare Centers as a PCCM plan and participates in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department has determined that there are no shared savings for calendar year (CY) 2009. The shared savings for CY 2010, CY 2011, CY 2012 and beyond have not yet been determined. The Department entered into a new five year contract with AIDS Healthcare Foundation effective January 1, 2012, through December 31, 2016.

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

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

BASE POLICY CHANGE NUMBER: 129

January 2014.

AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 has extended the gross premium tax through June 30, 2012. SB 78 extended the 2.35% gross premium tax through June 30, 2013, and imposed a 3.9375% statewide sales tax on managed care health plans effective July 1, 2013, through July 1, 2016.

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

**Reason for Change from Prior Estimate:**

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

**Methodology:**

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

**Duals:**

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

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

**Medi-Cal Only:**

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

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

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

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

**Funding:**

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

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

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 117 MCO Tax Mgd. Care Plans – Incr. Cap. Rates  
 PC 139 MCO Tax Mgd. Care Plans – Funding Adjustment  
 PC 140 MCO Tax Managed Care Plans

**Background:**

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

**Reason for Change from Previous Estimate:**

The contract with the Family Mosaic project was extended from July 1, 2013, through June 30, 2014, and is anticipated to be extended through June 30, 2015. Additionally, the estimated number of member months for FY 2013-14 dropped from 1,577 to 1,405.

**Methodology:**

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

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

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

FY 2013-14:  $1,405 \times \$1,848.75 = \mathbf{\$2,597,000}$  TF ( $\mathbf{\$1,298,500}$  GF)

FY 2014-15:  $1,465 \times \$1,848.75 = \mathbf{\$2,708,000}$  TF ( $\mathbf{\$1,354,000}$  GF)

**Funding:**

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

## PERSONAL CARE SERVICES (Misc. Svcs.)

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$2,695,250,000</b>	<b>\$2,799,250,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$2,695,250,000</b>	<b>\$2,799,250,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$2,695,250,000</b>	<b>\$2,799,250,000</b>

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreements:

03-75676 (PCSP)

09-86307 (IPO)

SB 1036 (Chapter 45, Statutes of 2012)

SB 1008 (Chapter 33, Statutes of 2012)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

FFP for the county cost of administering the PCSP is in the Other Administration section of the Estimate.

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

BASE POLICY CHANGE NUMBER: 171

**Reason for Change from Prior Estimate:**

Updated expenditure data received from CDSS.

**Methodology:**

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

(Dollars in Thousands)

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

**Funding:**

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

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

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. This policy change also includes adjustments due to reconciliations of state and federal data.
2. The Centers for Medicare and Medicaid set the 2013 Medicare Part A premium at \$441.00 and the Medicare Part B premium at \$104.90.
3. Using the average 2008-2013 premium growth rate 0.88%, the 2014 Medicare Part A premium is estimated to increase by \$3.90 to \$444.90. Based on the 2013 growth rate of 5.01%, the 2014 Medicare Part B premium is estimated to increase by \$5.30 to \$110.20.
4. Using the average 2008-2013 premium growth rate 0.88%, the 2015 Medicare Part A premium is estimated to increase by \$3.90 to \$448.80. Based on the 2013 growth rate of 5.01%, the 2015 Medicare Part B premium is estimated to increase by \$5.60 to \$115.80.

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

BASE POLICY CHANGE NUMBER: 172

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

**Funding:**

State General Fund (4260-101-0001)

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

## MEDICARE PAYMENTS - PART D PHASED-DOWN

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$1,474,761,000	\$1,453,897,000
- STATE FUNDS	\$1,474,761,000	\$1,453,897,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,474,761,000	\$1,453,897,000
STATE FUNDS	\$1,474,761,000	\$1,453,897,000
FEDERAL FUNDS	\$0	\$0

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2011	\$100.77
2012	\$102.76
2013	\$103.70
2014	\$97.40
2015	\$97.65 (estimated)

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

BASE POLICY CHANGE NUMBER: 173

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

<u>Fiscal Year</u>	<u>Total Payment</u>	<u>Ave.Monthly Beneficiaries</u>
FY 2010-11	\$1,049,777,643	1,113,792
FY 2011-12	\$1,367,279,250	1,150,028
FY 2012-13	\$1,454,929,918	1,176,313

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. The growth increase in the Medicare Part D PMPM for calendar year 2013 was 3.09% and Medi-Cal's PMPM increased to \$103.70.
2. The 2014 growth decreased 4.03 and Medi-Cal's estimated PMPM decreases to \$97.40.
3. The 2015 growth is assumed to increase 2.46% based on the average of annual percentage increase from Year 2011-2014 from *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM is \$97.65.
4. Phase-down payments have a two-month lag. For example, the invoice for the Medi-Cal beneficiaries eligible for Medicare Part D in January 2013 is received in February 2013 and payment is due in March 2013.
5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly dual eligible Part D enrollment data for July 2008 – August 2013.
6. The Phased-down Contribution is funded 100% by State General Fund.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
<b>FY 2013-14</b>	12	1,209,843	\$122,896,779	<b>\$1,474,761,000</b>
<b>FY 2014-15</b>	12	1,242,850	\$121,158,091	<b>\$1,453,897,000</b>

**Funding:**

State Only General Fund (4260-101-0001)

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

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

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

**DESCRIPTION****Purpose:**

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

**Authority:**

Interagency Agreement 01-15834

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

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

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

BASE POLICY CHANGE NUMBER: 174

**Methodology:**

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

(Dollars in Thousands)

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

**Funding:**

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

## DENTAL SERVICES

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$498,146,000</b>	<b>\$505,737,000</b>
<b>- STATE FUNDS</b>	<b>\$238,978,600</b>	<b>\$242,774,100</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$498,146,000</b>	<b>\$505,737,000</b>
<b>STATE FUNDS</b>	<b>\$238,978,600</b>	<b>\$242,774,100</b>
<b>FEDERAL FUNDS</b>	<b>\$259,167,400</b>	<b>\$262,962,900</b>

### DESCRIPTION

**Purpose:**

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

**Authority:**

Social Security Act, Title XIX

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

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

**Methodology:**

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

**DENTAL SERVICES**

BASE POLICY CHANGE NUMBER: 175

3. Full federal funding is available for refugees. The funding adjustment shifting normal state share to 100% federal funds for refugees is aggregated and shown in the Refugee Policy Change.

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

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

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

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

**Funding:**

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

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

100% GF (4260-101-0001)

## DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

The changes are due to updated expenditures.

**Methodology:**

1. The following estimates have been provided by CDDS.

**DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**

BASE POLICY CHANGE NUMBER: 176

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

**Funding:**

100% Title XIX (4260-101-0890)

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

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

Updated caseload.

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

BASE POLICY CHANGE NUMBER: 179

**Methodology:**

1. The following estimates have been provided by CDDS:

(In Thousands)

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

**Funding:**

100% Title XIX (4260-101-0890)

## MEDI-CAL TCM PROGRAM

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

Updated data became available concerning the TCM expenditures.

**Methodology:**

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

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

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

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

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

**Funding:**

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

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

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

AB 668 (Chapter 896, Statutes of 1998)

**Interdependent Policy Changes:**

PC 37 California Community Transitions Costs

**Background:**

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

**Reason for Change from Prior Estimate:**

The FY 2013-14 costs have decreased based on 5% of California Community Transitions (CCT) beneficiaries expected to use WPCS, instead of 25%.

**WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 181****Methodology:**

1. Assume the number of current NF A/B Level of Care (LOC) Waiver beneficiaries using Waiver PCS is estimated to increase by an average of nine per month in FY 2013-14 and FY 2014-15.
2. Assume the number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by one per month in FY 2013-14 and FY 2014-15.
3. The Department's CCT Demonstration Project expects to transition 365 beneficiaries out of inpatient extended health care facilities during FY 2013-14 and FY 2013-14. Based on actual data, 5% of the beneficiaries are expected to use Waiver PCS.
4. The average cost/hour is \$10.00 for FY 2013-14 and FY 2014-15.

**Funding:**

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

## EPSDT SCREENS

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Title 22, California Code of Regulations 51340(a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

Updated data reflected a decrease in the number of screens.

**Methodology:**

Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2013-14 and FY 2014-15, based on a historical trend dating back to July 2008.

**FY 2013-14**

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

**FY 2014-15**

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

## EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 182

**Funding:**

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

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

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14124.91  
 Social Security Act 1916 (e)  
 22 California Code of Regulations 50778 (Chapter 2, Article 15)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

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

**Methodology:**

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

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

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

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

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

**Funding:**

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

## LAWSUITS/CLAIMS

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

An additional lawsuit settlement.

**LAWSUITS/CLAIMS**  
**BASE POLICY CHANGE NUMBER: 189**

**Methodology:**

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

\* Represents potential totals.

**Funding:**

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

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

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FULL YEAR COST - TOTAL FUNDS	\$1,799,000	\$1,285,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,799,000	\$1,285,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,799,000	\$1,285,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA) #07-65689

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

The changes are due to delay in contract approval.

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

BASE POLICY CHANGE NUMBER: 190

**Methodology:**

1. Annual expenditures on the accrual basis are \$2,056,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.

(In Thousands)		
<b>FY 2013-14</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<u>\$1,799</u>	<u>\$1,799</u>
<b>FY 2014-15</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<u>\$1,285</u>	<u>\$1,285</u>

**Funding:**

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

## BASE RECOVERIES

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

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

**Methodology:**

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

## BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 202

(Dollars in Thousands)

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

**Funding:**

100% GF (4260-101-0001)

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

## PROVIDER FRAUD IMPACT TO DMC PROGRAM

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

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

### DESCRIPTION

**Purpose:**

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

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

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

**PROVIDER FRAUD IMPACT TO DMC PROGRAM**

BASE POLICY CHANGE NUMBER: 203

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

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

**Funding:**

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

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

## MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>ELIGIBILITY</u></b>	
1	TRANSITION OF HFP TO MEDI-CAL
2	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
4	AIM LINKED INFANTS 250-300% FPL
5	MEDI-CAL ADULT INMATE PROGRAMS
6	CHDP GATEWAY - PREENROLLMENT
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES
8	REFUGEES
9	MCHA VS. DHCS AND MRMIB
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
11	NEW QUALIFIED IMMIGRANTS
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
14	INCARCERATION VERIFICATION PROGRAM
15	PARIS-FEDERAL
16	PARIS-VETERANS
17	PARIS-INTERSTATE
212	AIM LINKED MOTHERS 200-300% FPL
<b><u>AFFORDABLE CARE ACT</u></b>	
18	ACA OPTIONAL EXPANSION
19	PAYMENTS TO PRIMARY CARE PHYSICIANS
20	COMMUNITY FIRST CHOICE OPTION
21	ACA MANDATORY EXPANSION
22	MENTAL HEALTH SERVICES EXPANSION
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS
27	USPSTF GRADE A AND B RECOMMENDATIONS
28	ACA DELAY OF REDETERMINATIONS
29	STATE-ONLY FORMER FOSTER CARE PROGRAM
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES
31	RECOVERY AUDIT CONTRACTOR SAVINGS
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION

## MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>AFFORDABLE CARE ACT</u></b>	
34	MANAGED CARE DRUG REBATES
205	HEALTH INSURER FEE
206	ACA EXPRESS LANE ENROLLMENT
210	ACA EXPANSION-PREGNANCY ONLY
<b><u>BENEFITS</u></b>	
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS
38	RESTORATION OF SELECT ADULT DENTAL BENEFITS
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS
41	YOUTH REGIONAL TREATMENT CENTERS
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING
43	CCT FUND TRANSFER TO CDSS AND CDDS
44	PEDIATRIC PALLIATIVE CARE WAIVER
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS
47	INCREASED FEDERAL MATCHING FUNDS FOR FPACT
48	HEARING AID CAP
49	SCHIP FUNDING FOR PRENATAL CARE
50	COPAYMENT FOR NON-EMERGENCY ER VISITS
51	WOMEN'S HEALTH SERVICES
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS
<b><u>PHARMACY</u></b>	
53	RESTORATION OF ENTERAL NUTRITION BENEFIT
54	NON FFP DRUGS
55	BCCTP DRUG REBATES
56	MEDICAL SUPPLY REBATES
57	FAMILY PACT DRUG REBATES
58	LITIGATION SETTLEMENTS
59	AGED AND DISPUTED DRUG REBATES
60	STATE SUPPLEMENTAL DRUG REBATES
61	FEDERAL DRUG REBATE PROGRAM

## MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>PHARMACY</u></b>	
211	<a href="#">MCO SUPPLEMENTAL DRUG REBATE</a>
<b><u>DRUG MEDI-CAL</u></b>	
66	VOLUNTARY INPATIENT DETOXIFICATION
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
68	ANNUAL RATE ADJUSTMENT
<b><u>MENTAL HEALTH</u></b>	
71	<a href="#">SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT</a>
72	ELIMINATION OF STATE MAXIMUM RATES
73	TRANSITION OF HFP - SMH SERVICES
74	KATIE A. V. DIANA BONTA
75	HEALTHY FAMILIES - SED
76	INVESTMENT IN MENTAL HEALTH WELLNESS
77	OVER ONE-YEAR CLAIMS
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
80	<a href="#">IMD ANCILLARY SERVICES</a>
81	CHART REVIEW
82	REIMBURSEMENT IN IMD ANCILLARY SERVICES COSTS
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>	
84	BTR - LIHP - MCE
85	MH/UCD & BTR—DSH PAYMENT
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
88	BTR—SAFETY NET CARE POOL
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
90	<a href="#">BTR—LOW INCOME HEALTH PROGRAM - HCCI</a>
91	MH/UCD & BTR—CCS AND GHPP
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

## MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>WAIVER--MH/UCD &amp; BTR</u></b>	
95	BTR—DESIGNATED STATE HEALTH PROGRAMS
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH
98	BTR—INCREASE SAFETY NET CARE POOL
99	MH/UCD—STABILIZATION FUNDING
100	<a href="#">MH/UCD &amp; BTR—DPH INTERIM &amp; FINAL RECONS</a>
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
104	MH/UCD—SAFETY NET CARE POOL
105	MH/UCD & BTR—MIA-LTC
106	MH/UCD & BTR—BCCTP
107	MH/UCD & BTR—DPH INTERIM RATE
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
109	HOSPITAL STABILIZATION
110	<a href="#">MH/UCD—FEDERAL FLEX. &amp; STABILIZATION-SNCP</a>
111	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY
<b><u>MANAGED CARE</u></b>	
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES
118	MANAGED CARE RATE RANGE IGTS
119	TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS
120	<a href="#">MANAGED CARE PUBLIC HOSPITAL IGTS</a>
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES
123	TRANSFER OF IHSS COSTS TO CDSS
124	RETRO MC RATE ADJUSTMENTS
127	MANAGED CARE EXPANSION TO RURAL COUNTIES
128	INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX
131	<a href="#">NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS</a>
132	CAPITATED RATE ADJUSTMENT FOR FY 2014-15
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF
134	EXTEND GROSS PREMIUM TAX
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE
136	GENERAL FUND REIMBURSEMENTS FROM DPHS

## MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>MANAGED CARE</u></b>	
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
138	FFS COSTS FOR MANAGED CARE ENROLLEES
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
140	<a href="#">MCO TAX MANAGED CARE PLANS</a>
141	SCAN TRANSITION TO MANAGED CARE
142	DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC
143	TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE
<b><u>PROVIDER RATES</u></b>	
24	AB 1629 ADD-ONS
144	FQHC/RHC/CBRC RECONCILIATION PROCESS
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
147	AIR AMBULANCE MEDICAL TRANSPORTATION
148	LTC RATE ADJUSTMENT
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS
150	<a href="#">HOSPICE RATE INCREASES</a>
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
152	NON-AB 1629 LTC RATE FREEZE
153	DENTAL RETROACTIVE RATE CHANGES
154	LABORATORY RATE METHODOLOGY CHANGE
155	10% PAYMENT REDUCTION FOR LTC FACILITIES
156	REDUCTION TO RADIOLOGY RATES
157	10% PROVIDER PAYMENT REDUCTION
<b><u>SUPPLEMENTAL PMNTS.</u></b>	
158	HOSPITAL QAF - HOSPITAL PAYMENTS
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
160	<a href="#">FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS</a>
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT
163	NDPH IGT SUPPLEMENTAL PAYMENTS
164	CERTIFICATION PAYMENTS FOR DP-NFS
165	CAPITAL PROJECT DEBT REIMBURSEMENT
166	FFP FOR LOCAL TRAUMA CENTERS

## MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>SUPPLEMENTAL PMNTS.</u></b>	
167	IGT PAYMENTS FOR HOSPITAL SERVICES
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
170	<a href="#">STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS</a>
<b><u>OTHER DEPARTMENTS</u></b>	
208	DENTAL CHILDREN'S OUTREACH AGES 0-3
<b><u>OTHER</u></b>	
177	ARRA HITECH - PROVIDER PAYMENTS
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
183	<a href="#">NONCONTRACT HOSP INPATIENT COST SETTLEMENTS</a>
184	CDDS DENTAL SERVICES
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS
187	AUDIT SETTLEMENTS
191	INDIAN HEALTH SERVICES
192	<a href="#">CIGARETTE AND TOBACCO SURTAX FUNDS</a>
193	ANTI-FRAUD ACTIVITIES
194	CLPP FUND
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE
196	AB 97 INJUNCTIONS
197	TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
199	RECOVERY OF PCS/IHSS
200	<a href="#">MEDICARE BUY-IN QUALITY REVIEW PROJECT</a>
201	IHSS REDUCTION IN SERVICE HOURS

## TRANSITION OF HFP TO MEDI-CAL

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**TRANSITION OF HFP TO MEDI-CAL**

REGULAR POLICY CHANGE NUMBER: 1

(In Thousands)			<b>County</b>
<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement*</b>
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)	
<b>Net</b>	<b>\$1,195,670</b>	<b>\$394,453</b>	<b>\$24,031</b>

(In Thousands)			<b>County</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>Reimbursement*</b>
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)	
<b>Net</b>	<b>\$1,266,927</b>	<b>\$412,890</b>	<b>\$30,534</b>

**Funding:**

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

100% Reimbursement (4260-610-0995)\*

## FAMILY PACT PROGRAM

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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.

Service Category	FY 2013-14		FY 2014-15	
	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
<b>Total</b>	<b>\$632,717,000</b>	<b>\$158,475,000</b>	<b>\$656,141,000</b>	<b>\$164,342,000</b>

#### 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
<b>Total</b>		<b>\$632,717</b>	<b>\$158,475</b>	<b>\$474,242</b>

##### 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
<b>Total</b>		<b>\$656,141</b>	<b>\$164,343</b>	<b>\$491,799</b>

## BREAST AND CERVICAL CANCER TREATMENT

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>Total</b>	<b>\$154,126</b>	<b>\$67,665</b>	<b>\$163,528</b>	<b>\$71,430</b>

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
<b>Total</b>		<b>\$67,665</b>	<b>\$86,461</b>	<b>\$154,126</b>
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
<b>Total</b>		<b>\$71,430</b>	<b>\$92,098</b>	<b>\$163,528</b>

## AIM LINKED INFANTS 250-300% FPL

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**AIM LINKED INFANTS 250-300% FPL**

REGULAR POLICY CHANGE NUMBER: 4

(In Thousands)	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2013-14</b>	<b>\$33,357</b>	<b>\$11,675</b>	<b>\$21,682</b>
(In Thousands)	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2014-15</b>	<b>\$33,357</b>	<b>\$11,675</b>	<b>\$21,682</b>

**Funding:**

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

## MEDI-CAL ADULT INMATE PROGRAMS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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	<u>FY 2013-14</u>				<u>FY 2014-15</u>			
Aged	365	x	20%	x 75% = <b>55</b>	365	x	20%	x 75% = <b>55</b>
Disabled	365	x	20%	x 15% = <b>11</b>	365	x	20%	x 15% = <b>11</b>
Pregnancy Event	365	x	20%	x 5% = <b>4</b>	365	x	20%	x 5% = <b>4</b>
Under 21	365	x	20%	x 5% = <b>4</b>	365	x	20%	x 5% = <b>4</b>

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

<u>FY 2013-14 &amp; FY 2014-15</u>						<u>TF</u>	<u>FF</u>
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
<b>Total</b>						<b>\$8,783,000</b>	<b>\$4,391,500</b>

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	<u>FY 2013-14</u>				<u>FY 2014-15</u>					
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.

<u>FY 2013-14</u>						<u>TF</u>	<u>FF</u>
(Rounded)							
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
<b>Total</b>						<b>\$5,896,000</b>	<b>\$2,948,000</b>

<u>FY 2014-15</u>						<u>TF</u>	<u>FF</u>
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
<b>Total</b>						<b>\$3,931,000</b>	<b>\$1,965,000</b>

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		<u>TF</u>	<u>FF</u>
263*	x	\$7,947	= \$2,090,000	\$1,045,000

**FY 2014-15**

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

**FY 2014-15**

LTC Eligible Months	PMPM		<u>TF</u>	<u>FF</u>
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****State**

	FY 2013-14		FY 2014-15	
	<u>TF</u>	<u>FF</u>	<u>TF</u>	<u>FF</u>
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
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**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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-

**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:

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

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

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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%	=	<b>23</b>
Inpatient Services	29	x	20%	=	<b>6</b>

(Rounded)

**County Inmates****FY 2013-14 & FY 2014-15**

Psychiatric Services	99	x	80%	=	<b>79</b>
Inpatient Services	99	x	20%	=	<b>20</b>

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**

						<b><u>TF</u></b>	<b><u>FF</u></b>
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
<b>Total</b>						<b>\$2,505,000</b>	<b>\$1,252,500</b>

**FY 2014-15**

						<b><u>TF</u></b>	<b><u>FF</u></b>
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
<b>Total</b>						<b>\$2,505,000</b>	<b>\$1,252,500</b>

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**

						<b><u>TF</u></b>	<b><u>FF</u></b>
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
<b>Total</b>						<b>\$10,428,000</b>	<b>\$5,214,000</b>

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)						
	<b>FY 2014-15</b>					
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
<b>Total</b>						<b>\$8,528,000 \$4,264,000</b>

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

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

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:**

- 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)

**MCHA VS. DHCS AND MRMIB**

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

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

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.

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

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
<b>Total</b>	<b>\$540,000</b>	<b>\$270,000</b>	<b>\$234,000</b>	<b>\$117,000</b>

**Funding:**

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

## COUNTY HEALTH INITIATIVE MATCHING (CHIM)

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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, Statutes 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:**

- Effective July 1, 2014, children participating in the CHIM program will transition into the Medi-Cal delivery system.
- 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	
<b>FY 2014-15</b>	<b>\$2,409</b>	<b>\$933</b>	<b>\$1,476</b>

**Funding:**

Title XXI FFP (4260-113-0890)

Title XXI GF (4260-113-0001)

County Health Initiative Matching Fund (CHIM) (4260-113-3055)

## NEW QUALIFIED IMMIGRANTS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)	<b>FY 2013-14</b>	<b>FY 2014-15</b>
FFS	\$106,568	\$106,568
Managed Care	\$20,539	\$20,539
Total	\$127,017	\$127,017
<b>FFP Repayment</b>	<b>\$63,554</b>	<b>\$63,554</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 6<sup>th</sup> birthday in the 133 percent program and ages 6 to the month of their 19<sup>th</sup> 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.

**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)

<b>FY 2013-14</b>		<b>GF</b>	<b>FF</b>	<b>TF</b>
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
<b>Net Impact</b>		<b>(\$56,409)</b>	<b>\$56,409</b>	<b>\$0</b>
<b>FY 2014-15</b>		<b>GF</b>	<b>FF</b>	<b>TF</b>
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
<b>Net Impact</b>		<b>(\$57,989)</b>	<b>\$57,989</b>	<b>\$0</b>

## CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

$\$9,787,000 \times 35.20\% \text{ non-emergency} = \$3,445,000$  (0 to 18 year olds)

$\$1,055,000 \times 35.20\% \text{ non-emergency} = \$371,000$  (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:

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

$14,594 \text{ eligible months} \times \$118.94 \text{ PMPM} \times 35.20\% \text{ non-emergency} = \$611,000$  (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:

$\$34,926,000 \times 6.64\% = \$2,319,000$

#### 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 =  $86,471 \text{ eligible months} \times \$118.94 \text{ PMPM} \times 6.64\% = \$683,000$

**CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN**

REGULAR POLICY CHANGE NUMBER: 13

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

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)

## INCARCERATION VERIFICATION PROGRAM

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

<b>FY 2013-14</b>	<b>TF</b>	<b>% in Base</b>	<b>Savings in Base</b>
Managed Care Savings	<u>(\$211,000)</u>	35.45%	<u>(\$75,000)</u>
<b>FY 2014-15</b>	<b>TF</b>	<b>% in Base</b>	<b>Savings in Base</b>
Managed Care Savings	<u>(\$348,000)</u>	23.86%	<u>(\$83,000)</u>

5. Total estimated savings not in the base trends:

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>
<b>Total Savings</b>	<u>(\$136,000)</u>	<u>(\$68,500)</u>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>
<b>Total Savings</b>	<u>(\$265,000)</u>	<u>(\$132,000)</u>

**Funding:**

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

## PARIS-FEDERAL

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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.

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

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

5. Total estimated savings not in the base trends:

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>
Managed Care Savings	(\$155,000)	(\$77,500)
FFS Savings	(\$456,000)	(\$228,000)
<b>Total</b>	<b>(\$611,000)</b>	<b>(\$305,500)</b>

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

**Funding:**

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

## PARIS-VETERANS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

## PARIS-INTERSTATE

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

<b>FY 2013-14</b>	<u>TF</u>	<u>% in Base</u>	<u>Savings in Base</u>
Managed Care Savings	(\$26,010,000)	87.37%	(\$22,726,000)
<b>FY 2014-15</b>	<u>TF</u>	<u>% in Base</u>	<u>Savings in Base</u>
Managed Care Savings	(\$38,477,000)	79.83%	(\$30,715,000)

5. Total estimated savings not in the base trends:

<b>FY 2013-14</b>	<u>TF</u>	<u>GF</u>
<b>Total Savings</b>	(\$3,284,000)	(\$1,642,000)
<b>FY 2014-15</b>	<u>TF</u>	<u>GF</u>
<b>Total Savings</b>	(\$7,762,000)	(\$3,881,000)

**Funding:**

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

## ACA OPTIONAL EXPANSION

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)	TF	GF	FF
<b>FY 2013-14</b>			
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 <sup>1,2</sup>	\$0	(\$47,983)	\$0
<b>Total</b>	<b>\$2,609,318</b>	<b>(\$47,983)</b>	<b>\$2,609,318</b>

**ACA OPTIONAL EXPANSION**  
REGULAR POLICY CHANGE NUMBER: 18

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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 <sup>1,2</sup>	\$0	(\$219,087)	\$0
<b>Total</b>	<b>\$6,586,221</b>	<b>(\$219,087)</b>	<b>\$6,586,221</b>

**Funding:**

(In Thousands)

**FY 2013-14:**

	<b>TF</b>	<b>SF</b>	<b>FF</b>
100% Title XIX Federal Share (4260-101-0890)	\$2,609,318	\$0	\$2,609,318
<sup>1</sup> 100% GF (4260-101-0001)	\$0	(\$47,983)	\$0
<sup>2</sup> MCO Tax Fund (4260-601-3156)	\$0	\$47,983	\$0
<b>Total</b>	<b>\$2,609,318</b>	<b>\$0</b>	<b>\$2,609,318</b>

**FY 2014-15:**

	<b>TF</b>	<b>SF</b>	<b>FF</b>
100% Title XIX Federal Share (4260-101-0890)	\$6,586,221	\$0	\$6,586,221
<sup>1</sup> 100% GF (4260-101-0001)	\$0	(\$219,087)	\$0
<sup>2</sup> MCO Tax Fund (4260-601-3156)	\$0	\$219,087	\$0
<b>Total</b>	<b>\$6,586,221</b>	<b>\$0</b>	<b>\$6,586,221</b>

## PAYMENTS TO PRIMARY CARE PHYSICIANS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)	
	<u>Annual FFP</u>
FFS	\$310,365
Managed Care	<u>\$749,835</u>
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.

## 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)	<u>TF</u>	<u>GF</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total Increase Payment</b>	<b>\$1,590,301</b>	<b>(\$27,926)</b>	<b>\$1,618,227</b>
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
<b>Total AB 97 Savings Lost</b>	<b>\$57,088</b>	<b>\$28,544</b>	<b>\$28,544</b>
<b>Total</b>	<b>\$1,715,678</b>	<b>\$34,763</b>	<b>\$1,680,916</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>GF</b>
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
<b>Total Increase Payment</b>	<b>\$530,101</b>	<b>(\$9,309)</b>	<b>\$539,410</b>
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
<b>Total AB 97 Savings Lost</b>	<b>\$50,347</b>	<b>\$25,173</b>	<b>\$25,173</b>
<b>Total</b>	<b>\$603,211</b>	<b>\$27,246</b>	<b>\$575,965</b>

**Funding:**

100% Title XIX (4260-101-0890)

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

100% GF (4260-101-0001)

## COMMUNITY FIRST CHOICE OPTION

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

## ACA MANDATORY EXPANSION

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

**ACA MANDATORY EXPANSION**

REGULAR POLICY CHANGE NUMBER: 21

(Dollars in Thousands)

	FY 2013-14		FY 2014-15	
	TF	GF	TF	GF
<b>Currently Eligible but Uninsured (0-64)</b>				
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
<b>Total</b>	\$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
<b>Net Impact to State</b>	<b>\$222,825</b>	<b>\$100,093</b>	<b>\$867,333</b>	<b>\$404,889</b>

**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
<b>Total</b>	<b>\$222,825</b>	<b>\$103,754</b>	<b>\$119,070</b>

**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
<b>Total</b>	<b>\$867,333</b>	<b>\$419,215</b>	<b>\$448,118</b>

## MENTAL HEALTH SERVICES EXPANSION

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

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

**Funding:**

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

100% Title XIX (4260-101-0890)

## ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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:

<b>FY 2013-14</b>						<b>TF</b>	<b>FF</b>	
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
<b>Total</b>	<b>428</b>						<b>\$24,252,000</b>	<b>\$24,252,000</b>
<b>FY 2014-15</b>						<b>TF</b>	<b>FF</b>	
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
<b>Total</b>	<b>428</b>						<b>\$49,922,000</b>	<b>\$49,922,000</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>FFS Total</b>	<b>\$10,012,000</b>	<b>\$18,671,000</b>
Managed Care	\$0	\$806,000
Retroactive Add-Ons-FFS	\$12,014,000	\$0
<b>Total*</b>	<b>\$22,027,000</b>	<b>\$19,477,000</b>

**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.

## ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2013-14</b>			
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
<b>Total</b>	<b>\$18,672</b>	<b>\$9,168</b>	<b>\$9,504</b>
<b>FY 2014-15</b>			
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
<b>Total</b>	<b>\$78,784</b>	<b>\$37,749</b>	<b>\$41,035</b>

## ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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:

Newly Eligible NQI Childless Adults:

	FY 2013-14		FY 2014-15	
	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:

	<b>\$14,493</b>	<b>\$5,254</b>	<b>\$56,924</b>	<b>\$20,638</b>
<b>Medi-Cal related cost avoidance:</b>				
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)

## USPSTF GRADE A AND B RECOMMENDATIONS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**USPSTF GRADE A AND B RECOMMENDATIONS**

REGULAR POLICY CHANGE NUMBER: 27

**FY 2013-14****Managed Care**

	<b>TF</b>	<b>GF</b>	<b>FFP</b>
Screening & Intervention Costs			
ACA Optional Expansion	\$2,251,000	\$0	\$2,251,000
ACA Mandatory Expansion & Medi-Cal Age 18-64	<u>\$6,660,000</u>	<u>\$3,330,000</u>	<u>\$3,330,000</u>
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	<u>\$296,000</u>	<u>\$148,000</u>	<u>\$148,000</u>
FFS Total	\$762,000	\$381,000	\$381,000

<b>Total</b>	<b>\$9,673,000</b>	<b>\$3,711,000</b>	<b>\$5,962,000</b>
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**FY 2014-15****Managed Care**

	<b>TF</b>	<b>GF</b>	<b>FFP</b>
Screening & Intervention Costs			
ACA Optional Expansion	\$17,425,000	\$0	\$17,425,000
ACA Mandatory Expansion & Medi-Cal Age 18-64	<u>\$42,827,000</u>	<u>\$21,414,000</u>	<u>\$21,414,000</u>
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	<u>\$3,862,000</u>	<u>\$1,931,000</u>	<u>\$1,931,000</u>
FFS Total	\$9,934,000	\$4,967,000	\$4,967,000

<b>Total</b>	<b>\$70,186,000</b>	<b>\$26,381,000</b>	<b>\$43,806,000</b>
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**Funding:**

100% Title XIX (4260-101-0890)

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

## ACA DELAY OF REDETERMINATIONS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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:

<b>FY 2013-14</b>	<b><u>TF</u></b>	<b><u>GF</u></b>	<b><u>FFP</u></b>
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)	<u>\$2,493,000</u>	<u>\$0</u>	<u>\$2,493,000</u>
<b>Total</b>	<b>\$6,653,000</b>	<b>\$2,052,500</b>	<b>\$4,600,500</b>
<b>FY 2014-15</b>	<b><u>TF</u></b>	<b><u>GF</u></b>	<b><u>FFP</u></b>
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)	<u>\$251,000</u>	<u>\$0</u>	<u>\$251,000</u>
<b>Total</b>	<b>\$668,000</b>	<b>\$205,500</b>	<b>\$462,500</b>

## STATE-ONLY FORMER FOSTER CARE PROGRAM

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2013-14 costs</b>	<b>\$796</b>	<b>\$796</b>	<b>\$0</b>

**Funding:**

100% State GF (4260-101-0001)

## 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.

**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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
FFS	\$0	(\$2,508)	\$2,508
Managed Care	\$0	(\$10,925)	\$10,925
Retroactive Savings	\$0	(\$26,851)	\$26,851
<b>Total</b>	<b>\$0</b>	<b>(\$40,284)</b>	<b>\$40,284</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
FFS	\$0	(\$5,099)	\$5,099
Managed Care	\$0	(\$21,851)	\$21,851
<b>Total</b>	<b>\$0</b>	<b>(\$26,950)</b>	<b>\$26,950</b>

**Funding:**

100% Title XIX (4260-101-0890)

100% GF (4260-101-0001)

## RECOVERY AUDIT CONTRACTOR SAVINGS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 31

### Methodology:

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

$\$12,506,375 \times 1\% \text{ recovery rate} = \$125,000 \text{ annual savings (rounded)}$

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.

$\$125,000 \text{ annual savings} \div 12 \text{ months} \div 12 \text{ month phase-in} = \$868 \text{ monthly phase-in}$

	<u>TF</u>	<u>GF</u>	<u>FF</u>
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)

## PRIVATE DSH REPLACEMENT PAYMENT REDUCTION

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>FY 2013-14</b>			
DSH 2013-14	(\$15,687,000)	(\$7,843,500)	(\$7,843,500)
<b>FY 2014-15</b>			
DSH 2013-14	(\$1,426,000)	(\$713,000)	(\$713,000)
DSH 2014-15	(\$15,687,000)	(\$7,843,500)	(\$7,843,500)
<b>Total</b>	<b>(\$17,113,000)</b>	<b>(\$8,556,500)</b>	<b>(\$8,556,500)</b>

### Funding:

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

## DISPROPORTIONATE SHARE HOSPITAL REDUCTION

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>FY 2013-14</b>	<b>TF</b>	<b>GF**</b>	<b>FF</b>	<b>IGT*</b>
DSH 2013-14	<b>(\$43,634,000)</b>	<b>(\$275,000)</b>	<b>(\$29,904,000)</b>	<b>(\$13,455,000)</b>
<b>FY 2014-15</b>				
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)
<b>Total</b>	<b>(\$47,601,000)</b>	<b>(\$300,000)</b>	<b>(\$32,623,000)</b>	<b>(\$14,678,000)</b>

**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)\*\*

## MANAGED CARE DRUG REBATES

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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**

$$\begin{aligned} \$280,000,000 \times 90\% &= \$252,000,000 \\ \$252,000,000 + \$136,347,000 &= \mathbf{\$388,347,000} \end{aligned}$$

4. For FY 2014-15, assume 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**

$$\begin{aligned} (\$280,000,000 \times 105\%) \times 90\% &= \$264,600,000 \\ \$264,600,000 + \$27,829,000 &= \mathbf{\$292,429,000} \end{aligned}$$

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
<b>Total FY 2013-14</b>	<b>\$ 388,347</b>

**Managed Care Drug Rebates FY 2014-15**

Retroactive Collections (2010Q1 – 2013Q1)	\$ 28,500
To be Collected from FY 2013-2014	\$ 264,000
<b>Total FY 2014-15</b>	<b>\$ 292,500</b>

**Funding:**

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

## ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

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

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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
<b>FY 2013-14 Total</b>	<b>\$145,537</b>	<b>\$145,537</b>
FY 2014-15 Interim Payments	\$141,124	\$141,124
FY 2008-09 Reconciliation	\$4,000	\$4,000
<b>FY 2014-15 Total</b>	<b>\$145,124</b>	<b>\$145,124</b>

### 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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	<b>\$22,446</b>	<b>\$1,474</b>	<b>\$24,679</b>	<b>\$2,707</b>
CDDS prior year costs	<b>\$28,964</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
Net	\$37,852	(\$5,305)	\$6,516	(\$6,375)

### Funding:

100% GF (4260-101-0001)

MFP Federal Grant (4260-106-0890)

## RESTORATION OF SELECT ADULT DENTAL BENEFITS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 eligibles for optional ACA for May 2014 to June 2014 decreased. The estimate for FY 2014-15 is for a complete year.

**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)

	<u>TF</u>	<u>FFP</u>	<u>GF</u>
<b>Benefit Costs</b>			
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
<b>Total Benefit Costs</b>	<b>\$10,888</b>	<b>\$7,572</b>	<b>\$3,315</b>

**FY 2014-15**

(Dollar in Thousands)

	<u>TF</u>	<u>FFP</u>	<u>GF</u>
<b>Benefit Costs</b>			
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
<b>Total Benefit Costs</b>	<b>\$239,532</b>	<b>\$166,591</b>	<b>\$72,941</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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
<b>FY 2013-14</b>	<b>\$40,464</b>	\$20,232	\$20,232
<b>FY 2014-15</b>	<b>\$40,464</b>	\$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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:  
 $\$3,477,000 \times 70\% = \$2,434,000$  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)

<b>FY 2013-14</b>	<b>TF</b>	<b>FFP</b>	<b>GF</b>
HPSM	\$39,690	\$19,845	\$19,845
UCLA-IE	\$300	\$150	\$150
<b>Total</b>	<b>\$39,990</b>	<b>\$19,995</b>	<b>\$19,995</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>FFP</b>	<b>GF</b>
HPSM	\$34,020	\$17,010	\$17,010
UCLA-IE	\$150	\$75	\$75
<b>Total</b>	<b>\$34,170</b>	<b>\$17,085</b>	<b>\$17,085</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
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
<b>Total FY 2013-14</b>	<b>\$5,085,000</b>	<b>\$776,000</b>	<b>\$4,309,000</b>
<b>FY 2014-15</b>			
*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
<b>Total FY 2014-15</b>	<b>\$6,345,000</b>	<b>\$34,000</b>	<b>\$6,311,000</b>

\* 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)

## DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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.

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
FFS (lagged)	\$4,467,000	\$2,233,500	\$2,233,500
Managed Care	\$164,000	\$82,000	\$82,000
<b>Total FY 2013-14</b>	<b>\$4,631,000</b>	<b>\$2,315,500</b>	<b>\$2,315,500</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
FFS	\$4,677,000	\$2,338,500	\$2,338,500
Managed Care	\$164,000	\$82,000	\$82,000
<b>Total FY 2014-15</b>	<b>\$4,841,000</b>	<b>\$2,420,500</b>	<b>\$2,420,500</b>

**Funding:**

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

## CCT FUND TRANSFER TO CDSS AND CDDS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>Total</b>	<b>\$2,678,000</b>	<b>\$3,415,000</b>

**Funding:**

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

## PEDIATRIC PALLIATIVE CARE WAIVER

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>GF</u>	<u>FF</u>	<u>TF</u>
<b>FY 2013-14</b>	<b>\$270,000</b>	<b>\$270,000</b>	<b>\$540,000</b>
<b>FY 2014-15</b>	<b>\$270,000</b>	<b>\$270,000</b>	<b>\$540,000</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

## INCREASED FEDERAL MATCHING FUNDS FOR FPACT

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)			<b>New FFP</b>
Total Cost			
\$3,969 x 90%	=		\$3,572
\$444 x 50%	=		\$222
<b>\$4,413</b>			<b>\$3,794</b>

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)	<b>GF</b>	<b>FF</b>
<b>FY 2013-14 Savings</b>	<b>(\$3,794)</b>	\$3,794
<b>FY 2014-15 Savings</b>	<b>(\$3,794)</b>	\$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)

## HEARING AID CAP

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:**

- Savings began on July 1, 2012.
- Actual annual hearing aid expenditures for FY 2010-11 were \$22,329,000 for 25,868 unduplicated users.
- 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)
<b>Total Annual Savings</b>	<b>(\$1,434)</b>	<b>(\$717)</b>	<b>(\$717)</b>

#### **FY 2013-14**

FFS	(\$389)	(\$194)	(\$195)
Managed Care	(\$1,045)	(\$522)	(\$523)
<b>Total FY 2013-14</b>	<b>(\$1,434)</b>	<b>(\$717)</b>	<b>(\$717)</b>

#### **FY 2014-15**

FFS	(\$389)	(\$194)	(\$194)
Managed Care	(\$1,045)	(\$522)	(\$522)
<b>Total FY 2014-15</b>	<b>(\$1,434)</b>	<b>(\$717)</b>	<b>(\$717)</b>

#### **Funding:**

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

## SCHIP FUNDING FOR PRENATAL CARE

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:**

- 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.
- 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:	$\$135,325,000 \times .65 =$	\$87,961,000 FFP
FY 2014-15:	$\$135,325,000 \times .65 =$	\$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:

<b>FY 2013-14 Savings:</b>	\$87,961,000 + \$4,090,000 =	<b>\$92,051,000</b>
<b>FY 2014-15 Savings:</b>	\$87,961,000 + \$4,090,000 =	<b>\$92,051,000</b>

**Funding:**

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

GF (4260-101-0001)

## COPAYMENT FOR NON-EMERGENCY ER VISITS

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

## WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 51  
 IMPLEMENTATION DATE: 11/2013  
 ANALYST: Randolph Alarcio  
 FISCAL REFERENCE NUMBER: 1770

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>Benefit</b>	<b>FMAP*</b>	<b>FY 2013-14 TF</b>	<b>FY 2014-15 TF</b>
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
<b>Total Savings</b>		<b>(\$12,011,000)</b>	<b>(\$10,351,000)</b>

\*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.

**WOMEN'S HEALTH SERVICES**

REGULAR POLICY CHANGE NUMBER: 51

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
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
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
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)

## CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 52  
 IMPLEMENTATION DATE: 12/2008  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 1222

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

## RESTORATION OF ENTERAL NUTRITION BENEFIT

REGULAR POLICY CHANGE NUMBER: 53  
 IMPLEMENTATION DATE: 5/2014  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1801

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

$\$28,892,000 \times (2/12 \text{ months}) = \$4,815,333$

6. There is a payment lag of 0.6970

$\$4,815,333 \times 0.6970 = \$3,356,000$

7. Total Expenditures:

(Dollars in Thousands)	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>Total FY 2013-14</b>	<b>\$ 3,356</b>	<b>\$ 1,678</b>	<b>\$ 1,678</b>
<b>Total FY 2014-15</b>	<b>\$ 28,892</b>	<b>\$ 14,446</b>	<b>\$14,446</b>

**Funding:**

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

## NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 54  
 IMPLEMENTATION DATE: 3/2007  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 108

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**NON FFP DRUGS**  
REGULAR POLICY CHANGE NUMBER: 54

(Dollars in  
Thousands)

	<u>Non-FFP Drug Expenditures</u>	<u>Est. FFP Repayment</u>
<b>FY 2013-14</b>	\$3,840	<b>\$1,920</b>
<b>FY 2014-15</b>	\$4,154	<b>\$2,077</b>

**Funding:**

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

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

## BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 55  
 IMPLEMENTATION DATE: 1/2010  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1433

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**BCCTP DRUG REBATES**  
REGULAR POLICY CHANGE NUMBER: 55

**Funding:**

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

## MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 56  
 IMPLEMENTATION DATE: 10/2006  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1181

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>Est. FY 2013-14</b>	<b>\$ 18,321,000</b>
<b>Est. FY 2014-15</b>	<b>\$ 18,321,000</b>

**Funding:**

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

## FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 57  
 IMPLEMENTATION DATE: 12/1999  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 51

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

<u>Fiscal Year</u>	<u>FPACT Drug Expenditures</u>	<u>FPACT Rebate</u>
FY 2012-13	\$148,213	(\$70,090)
<b>Est. FY 2013-14</b>	\$152,985	<b>(\$72,232)</b>
<b>Est. FY 2014-15</b>	\$161,687	<b>(\$74,815)</b>

	<u>TF</u>	<u>50% FFP</u>	<u>90% FFP</u>
<b>FY 2013-14</b>	<b>(\$72,232)</b>	(\$5,063)	(\$67,169)
<b>FY 2014-15</b>	<b>(\$74,815)</b>	(\$5,245)	(\$69,570)

**Funding:**

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

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

## LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 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.

## LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 58

**Methodology:**

The following settlements are expected to be received in FY 2013-14:

	<b>FY 2013-14</b>
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	<b>(\$81,772,000)</b>

**Funding:**

100% GF (4260-101-0001)

## AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59  
 IMPLEMENTATION DATE: 4/2004  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1182

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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
	<b>\$ 150,000,000</b>	<b>\$ 74,611,200</b>	<b>\$ 75,388,800</b>

(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
	<b>\$ 150,000,000</b>	<b>\$ 74,611,200</b>	<b>\$ 75,388,800</b>

**Funding:**

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

90% Title XIX / 10% GF (4260-101-0001/0890)

## STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 60  
 IMPLEMENTATION DATE: 1/1991  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 54

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)
<b>Total</b>	<b>(\$165,789,000)</b>	<b>(\$82,465,000)</b>	<b>(\$180,942,000)</b>	<b>(\$90,001,000)</b>

**Funding:**

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

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

## FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 61  
 IMPLEMENTATION DATE: 7/1990  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 55

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)
<b>Total</b>	<b>(\$1,335,187,000)</b>	<b>(\$608,133,000)</b>	<b>(\$1,457,218,000)</b>	<b>(\$668,831,000)</b>

**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)

## VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 66  
 IMPLEMENTATION DATE: 1/2014  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1811

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>FY 2013-14</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rate</b>	<b>Total</b>
Regular	1,343	5	\$ 1,490	\$ 10,001,625
Mandatory	100	5	\$ 1,490	\$ 745,000
Optional	252	5	\$ 1,490	\$ 1,877,400
				<u>\$ 12,624,025</u>

<b>FY 2014-15</b>	<b>Caseload</b>	<b>UOS</b>	<b>Rate</b>	<b>Total</b>
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
				<u>\$ 27,341,500</u>

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.

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
FY 2013-14	\$12,624,000	\$9,468,000	\$3,156,000
FY 2014-15	\$27,342,000	\$0	\$20,507,000
		<u>\$9,468,000</u>	<u>\$23,663,000</u>

**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**

	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2013-14</b>	\$ 9,468	\$ <b>4,030</b>	\$ <b>5,438</b>
<b>FY 2014-15</b>	\$ 23,663	\$ <b>9,940</b>	\$ <b>13,723</b>

**Funding:**

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

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

## DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 67  
 IMPLEMENTATION DATE: 1/2013  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1723

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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**

<b>Settlements</b>	<b>TF</b>	<b>CF</b>	<b>FFP</b>
Regular (Item 103)	\$3,207,000	\$398,000	\$2,808,000
Perinatal (Item 102)	\$222,000	(\$5,000)	\$228,000
<b>Total for FY 2013-14</b>	<b>\$3,429,000</b>	<b>\$393,000</b>	<b>\$3,036,000</b>

**FY 2012-13**

<b>Settlements</b>	<b>TF</b>	<b>CF</b>	<b>FFP</b>
Regular (Item 103)	\$3,207,000	\$398,000	\$2,808,000
Perinatal (Item 102)	\$222,000	(\$5,000)	\$225,000
<b>Total for FY 2014-15</b>	<b>\$3,429,000</b>	<b>\$393,000</b>	<b>\$3,036,000</b>

**Funding:**

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

## ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 68  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1724

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>Regular-Services</b>	<b>FY 2013-14 Required Rates</b>	<b>FY 2014-15 Required Rates</b>	<b>Incremental Difference</b>
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)

<b>Perinatal-Services</b>	<b>FY 2013-14 Required Rates</b>	<b>FY 2014-15 Required Rates</b>	<b>Incremental Difference</b>
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
<b>Total for Regular</b>	<b>(\$20,283,849)</b>

**Perinatal (Program 25)**

Narcotic Treatment	(\$4,278)
Intensive Outpatient	\$58,091
Outpatient Drug Free	\$14,926
Perinatal	\$81,676
<b>Total for Perinatal</b>	<b>\$150,416</b>

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.

	<u>Accrual</u>	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Regular	(\$20,283,849)	(\$15,212,887)	(\$5,070,962)
Perinatal	\$150,416	\$112,812	\$37,604
<b>Total</b>	<b>(\$20,133,433)</b>	<b>(\$15,100,075)</b>	<b>(\$5,033,358)</b>

**ANNUAL RATE ADJUSTMENT**

REGULAR POLICY CHANGE NUMBER: 68

6. The annual rate adjustment for FY 2014-15 is:

	<u>Total</u>	<u>GF</u>	<u>FFP</u>	<u>County Funds*</u>
FY 2013-14	(\$15,100,075)	(\$744,368)	(\$7,077,628)	(\$7,278,079)
<b>FY 2014-15</b>	(\$5,033,358)	<b>(\$248,123)</b>	<b>(\$2,359,209)</b>	(\$2,426,027)

\*County funds are not budgeted.

**Funding:**

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

## SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 71  
 IMPLEMENTATION DATE: 2/2014  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1458

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

	<u>FFP - REGULAR</u>	<u>FFP - ARRA</u>	<u>TOTAL FFP</u>
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
<b>Total for FY 2013-14</b>	<b>\$238,724</b>	<b>\$55,095</b>	<b>\$293,819</b>
FY 2011-12 FFP	\$107,898	\$0	\$107,898
<b>Total for FY 2014-15</b>	<b>\$107,898</b>	<b>\$0</b>	<b>\$107,898</b>

**Funding:**

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

## ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 72  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1759

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)				
<b>FY 2012-13</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP</b>	<b>County</b>
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)				
<b>FY 2013-14</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP</b>	<b>County</b>
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)				
<b>FY 2014-15</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP</b>	<b>County</b>
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)				
<b>FY 2012-13</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP*</b>	<b>County</b>
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)				
<b>FY 2013-14</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP*</b>	<b>County</b>
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
<b>Total FY 2013-14</b>	<b>\$247,019</b>	<b>\$121,777</b>	<b>\$2,413</b>	<b>\$122,829</b>

**ELIMINATION OF STATE MAXIMUM RATES**

REGULAR POLICY CHANGE NUMBER: 72

		(In Thousands)			
<b>FY 2013-14</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP*</b>	<b>County</b>	
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)			
<b>FY 2014-15</b>	<b>TF</b>	<b>FFP</b>	<b>M-CHIP*</b>	<b>County</b>	
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	
<b>Total FY 2014-15</b>	<b>\$265,752</b>	<b>\$130,878</b>	<b>\$2,599</b>	<b>\$132,275</b>	

**Funding:**

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

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

## TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 73  
 IMPLEMENTATION DATE: 1/2013  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1719

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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)

	<b>TF</b>	<b>FFP</b>	<b>County</b>
SED Services	\$26,878	\$17,471	\$9,407
Outpatient	\$37,814	<b>\$24,579</b>	\$13,235
Inpatient	\$12,369	<b>\$8,040</b>	\$4,329
<b>FY 2013-14</b>	\$77,061	\$50,090	\$26,971

(In Thousands)

	<b>TF</b>	<b>FFP</b>	<b>County</b>
SED Services	\$35,540	\$23,101	\$12,439
Outpatient	\$48,618	<b>\$31,602</b>	\$17,016
Inpatient	\$15,902	<b>\$10,336</b>	\$5,566
<b>FY 2014-15</b>	\$100,060	\$65,039	\$35,021

### Funding:

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

**KATIE A. V. DIANA BONTA**

REGULAR POLICY CHANGE NUMBER: 74  
 IMPLEMENTATION DATE: 1/2013  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1718

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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.

$$\$53,502,000 \div 12 \text{ months} \times 6 \text{ months} = \$26,751,000$$

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
<b>FY 2013-14</b>	<b>\$55,910</b>	<b>\$27,955</b>	<b>\$27,955</b>
FY 2013-14	\$15,516	\$7,758	\$7,758
FY 2014-15	\$37,986	\$18,993	\$18,993
<b>FY 2014-15</b>	<b>\$53,502</b>	<b>\$26,751</b>	<b>\$26,751</b>

**Funding:**

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

**HEALTHY FAMILIES - SED**

REGULAR POLICY CHANGE NUMBER: 75  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1712

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>TOTAL FY 2013-14</b>	<b>\$28,817</b>	<b>\$18,731</b>	<b>\$10,086</b>

**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	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2012-13	\$292	\$190	\$102
FY 2013-14	\$8,011	\$5,207	\$2,804
FY 2014-15	\$19,861	\$12,910	\$6,951
<b>TOTAL FY 2014-15</b>	<b>\$28,164</b>	<b>\$18,307</b>	<b>\$9,857</b>

**Funding:**

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

## INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER: 76  
 IMPLEMENTATION DATE: 1/2014  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1805

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

	<b>FY 2013-14</b>	<b>FY 2014-15</b>
Mobile Crisis Teams	\$1,400	\$2,800
600 Triage Personnel	\$11,000	\$22,000
<b>Total</b>	<b>\$12,400</b>	<b>\$24,800</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:**

- One-year claims are based on actual claims received from the counties.

	(In Thousands)		
	<u>TF</u>	<u>FFP</u>	<u>County</u>
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)

## SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT

REGULAR POLICY CHANGE NUMBER: 78  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1716

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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).

**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:**

- 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)

	<u>TF</u>	<u>FFP</u>	<u>County</u>
<b>FY 2013-14</b>	\$4,540	<b>\$2,270</b>	\$2,270
<b>FY 2014-15</b>	\$4,540	<b>\$2,270</b>	\$2,270

**Funding:**

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

## 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.

**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.

<u>Date of Overpayment Discovery</u>	<u>FY 2013-14 Repayment</u>	<u>FY 2014-15 Repayment</u>
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	
<b>Total:</b>	<b>\$7,204,000</b>	
	<b>(\$200,000)</b>	GF
		<b>(\$200,000) Reimbursement</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>Services Received</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
10/01/10 - 09/30/11	\$6,000	\$0
10/01/11 - 09/30/12	\$0	\$6,000
<b>Total</b>	<b>\$6,000</b>	<b>\$6,000</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

	<u>TF</u>	<u>FFP</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>Dates of Service</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
FY 2008-09	(\$12,000)	\$0
FY 2009-10	\$0	\$(12,000)
<b>Total</b>	<b>(\$12,000)</b>	<b>(\$12,000)</b>

### Funding:

100% General Fund (4260-101-0001)

Reimbursement (4260-610-0995)

## INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1713

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net</u>
<b>Interim Settlement (FY 2008-09)</b>			
Children and Adults	\$0	(\$24,540)	(\$24,540)
M-CHIP*	\$69	(\$1,419)	(\$1,350)
Healthy Families*	\$1,307	(\$2,353)	(\$1,046)
<b>Interim Settlement (FY 2009-10)</b>			
Children and Adults	\$56,470	(\$76,075)	(\$19,605)
M-CHIP*	\$2,983	(\$2,052)	\$931
Healthy Families*	\$89	(\$3,886)	(\$3,797)
<b>Interim Settlement (FY 2010-11)</b>			
Children and Adults	\$51,645	(\$73,696)	(\$22,051)
M-CHIP*	\$802	(\$2,646)	(\$1,844)
Healthy Families*	\$1,051	(\$1,952)	(\$901)
<b>Final Settlement (Multi-Years)</b>			
Children and Adults	\$46,576	(\$42,259)	\$4,317
M-CHIP*	\$959	(\$219)	\$740
Healthy Families*	\$1,436	(\$1,827)	(\$391)
<b>Total FY 2013-14</b>	<b>\$163,387</b>	<b>(\$232,924)</b>	<b>(\$69,537)</b>

4. Cost settlements prior to realignment may consist of General Fund (GF) and federal financial participation (FFP).

(Dollars In Thousands)

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
Children and Adults	(\$34,102)	\$27,777	(\$61,879)
M-CHIP*	(\$1,523)	\$0	(\$1,523)
Healthy Families*	(\$6,135)	\$0	(\$6,135)
<b>Total FY 2013-14</b>	<b>(\$41,760)</b>	<b>\$27,777</b>	<b>(\$69,537)</b>

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**BTR - LIHP - MCE**  
**REGULAR POLICY CHANGE NUMBER: 84**

The estimated MCE payments on a cash basis are:

(Dollars In Thousands)

<b>FY 2013-14</b>	<b>TF</b>	<b>IGT CAP</b>	<b>IGT-FQHC</b>	<b>FFP</b>	<b>CPE*</b>
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	
<b>Total**</b>	<b>\$5,495,397</b>	<b>\$2,204,075</b>	<b>\$134,711</b>	<b>\$3,156,612</b>	<b>\$817,827</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF**</b>	<b>FF</b>	<b>IGT*</b>
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
	<b>\$1,559,070</b>	<b>\$13,678</b>	<b>\$1,254,544</b>	<b>\$330,848</b>
<b>FY 2014-15</b>				
DSH 2013-14	\$141,895	\$917	\$97,238	\$43,740
DSH 2014-15	\$1,560,851	\$10,083	\$1,069,623	\$481,145
	<b>\$1,702,746</b>	<b>\$11,000</b>	<b>\$1,166,861</b>	<b>\$524,885</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>Demonstration Year</b>	<b>Total Computable</b>	<b>DSRIP</b>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>FF</b>	<b>IGT</b>
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
<b>Total</b>	<b>\$1,485,648</b>	<b>\$742,824</b>	<b>\$742,824</b>
<b>FY 2014-15</b>			
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
<b>Total</b>	<b>\$1,892,310</b>	<b>\$946,155</b>	<b>\$946,155</b>

## **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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total FY 2013-14</b>	<b>\$603,508,000</b>	<b>\$301,754,000</b>	<b>\$301,754,000</b>
<b>FY 2014-15</b>			
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
<b>Total FY 2014-15</b>	<b>\$534,994,000</b>	<b>\$267,497,000</b>	<b>\$267,497,000</b>

## **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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:**

- 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.
- The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands)	<b>State-Only Funded Programs</b>	<b>Due to DPHs</b>
<b>Demonstration Year</b>		
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

- 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.
- The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)	<b>FY 2013-14</b>	<b>FY 2014-15</b>
<b>Demonstration Year</b>	<b>FF</b>	<b>FF</b>
2012-13	\$32,167	
2013-14	\$285,083	\$25,917
2014-15		\$216,333
<b>Total</b>	<b>\$317,250</b>	<b>\$242,250</b>

**Funding:**

100% Health Care Support Fund (4260-601-7503)

## MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 89  
 IMPLEMENTATION DATE: 7/2005  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1085

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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:

	<u>TF</u>	<u>SF</u>	<u>FF</u>
<b>FY 2013-14</b>			
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
<b>Cash Expenditures to Hospitals</b>	<b>\$248,602,000</b>	<b>\$124,301,000</b>	<b>\$124,301,000</b>
SB 335 Reduction	\$17,500,000	\$8,750,000	\$8,750,000
FY 2013-14 Ending Balance	\$0	\$0	\$0
<b>FY 2014-15</b>			
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
<b>Cash Expenditures to Hospitals</b>	<b>\$243,001,000</b>	<b>\$121,500,500</b>	<b>\$121,500,500</b>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>IGT-FQHC</b>	<b>FFP</b>
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
<b>Total*</b>	<b>\$180,186</b>	<b>\$44,904</b>	<b>\$135,282</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**MH/UCD & BTR—CCS AND GHPP**

REGULAR POLICY CHANGE NUMBER: 91

The estimated CCS/GHPP federal reimbursements are:

(Dollars in Thousands)	<b>CCS</b>	<b>GHPP</b>	<b>Total</b>
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)	<b>CCS FF</b>	<b>GHPP FF</b>	<b>Total</b>
<b>FY 2013-14</b>			
DSHP-BTR (DY 2013-14)	\$ 78,773	\$ 44,438	\$ 123,211
DY 2010-11 Final Reconciliation	\$ 4,366	\$ 2,281	\$ 6,647
<b>Total</b>	<b>\$ 83,139</b>	<b>\$ 46,719</b>	<b>\$ 129,858</b>

<b>FY 2014-15</b>			
DSHP-BTR (DY 2014-15)	\$ 78,773	\$ 44,438	\$ 123,211
DY 2011-12 Final Reconciliation	<u>(\$ 7,368)</u>	<u>\$ 3,833</u>	<u>(\$ 3,535)</u>
<b>Total</b>	<b>\$ 71,405</b>	<b>\$ 48,271</b>	<b>\$ 119,676</b>

**Funding:**

100% Health Care Support Fund (4260-601-7503)

**BTR - LIHP - DSRIP HIV TRANSITION PROJECTS**

REGULAR POLICY CHANGE NUMBER: 92  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1672

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>IGT</b>	<b>FFP</b>
2012-13	\$55,000	\$27,500	\$27,500
2013-14	\$55,000	\$27,500	\$27,500
<b>Total</b>	<b>\$110,000</b>	<b>\$55,000</b>	<b>\$55,000</b>

### Funding:

DSRIP IGT Fund (4260-601-3172)  
Title XIX FFP (4260-101-0890)

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

<b>FY 2013-14</b>	<b>TF</b>	<b>IGT*</b>	<b>LIHP</b>	<b>FFP**</b>
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
<b>Total</b>	<b>\$100,000</b>	<b>\$50,000</b>	<b>\$0</b>	<b>\$50,000</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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	
	TF	FF
<b>FY 2013-14</b>		
DPH 2013-14	\$ 82,000	\$ 82,000
<b>FY 2014-15</b>		
DPH 2014-15	\$ 82,000	\$ 82,000

**Funding:**

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

**BTR—DESIGNATED STATE HEALTH PROGRAMS**

REGULAR POLICY CHANGE NUMBER: 95  
 IMPLEMENTATION DATE: 11/2010  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1571

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

<b>State Only Medical Programs</b>
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)
<b>Workforce Development Programs</b>
Office of Statewide Health Planning & Development (OSHPD) <ul style="list-style-type: none"> <li>· Song-Brown HealthCare Workforce Training</li> <li>· Steven M. Thompson Physician Corps Loan Repayment Program</li> <li>· Mental Health Loan Assumption Program</li> </ul>
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)	<b>Total DSHP (Accrual Basis)</b>		<b>Included in this PC (Cash Basis)</b>	
	FFP	FFP	FFP	FFP
	DY 2013-14	DY 2014-15	FY 2013-14	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	<b>\$397,536</b>	<b>\$255,942</b>

**Funding:**

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

## BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 96  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1576

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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.  
 $380 \text{ total inmate applications processed} \times 74\% \text{ LIHP} \times 96\% \text{ approval rate} = 270$
  - Assume 20.8% of eligible LIHP inmates will receive two inpatient hospital services during a month.  
 $270 \text{ approved application} \times 20.8\% = 56 \text{ additional monthly inpatient stays}$
  - $270 \text{ LIHP approved inmate applications} + 56 \text{ additional monthly stays} = 326$
5. Assume 18 average monthly approved inpatient stays for each LIHP.
  - $326 \text{ total average monthly inpatient stays} \div 18 \text{ LIHPs} = 18$
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
  - $326 \text{ monthly approved inpatient stays} \times \$18,205 \text{ average cost} \times 12 \text{ months} = \$71,217,960 \text{ TF}$
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:  $2 \text{ LIHPs} \times 18 \text{ approved applications} \times \$18,205 \text{ average cost} \times 12 \text{ months} = \$7,864,560$
  - Effective October 1, 2011:  $16 \text{ LIHPs} \times 18 \text{ approved applications} \times \$18,205 \text{ average cost} \times 9 \text{ months} = \$47,187,360$
8. For FY 2012-13, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be \$71,217,960.

**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)

	<b>TF</b>	<b>FF</b>	<b>CPE</b>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>FF</b>	<b>CPE</b>
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
<b>Total**</b>	<b>\$56,473</b>	<b>\$56,473</b>	<b>\$56,473</b>

**Funding:**

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

\*Not included in Total Fund

\*\*Amounts may differ due to rounding

## MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 97  
 IMPLEMENTATION DATE: 7/2009  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1162

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

<b>FY 2013-14</b>	<b>FF</b>	<b>GF</b>
HCCI Rollover		
DY 2012-13	(\$48.50)	\$0.00
DY 2013-14	(\$13.00)	\$0.00
Total	(\$61.50)	\$0.00
<b>Amount to SNCP-DPHs</b>	<b>\$30.75</b>	<b>\$0.00</b>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

DPHs

**TF****\$13,988****GF****\$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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>FF</b>
2005-06 Final Reconciliation	<u>\$11,877</u>
<b>FY 2014-15</b>	
2006-07 Final Reconciliation	<b>\$108,328</b>

**Funding:**

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

## UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1769

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

$$29,000 \text{ patients annually} \times 15\% = 4,350 \text{ IHS eligible uninsured individuals}$$

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.

$$4,350 \text{ individuals} \times 3 \text{ encounters} \times \$330 = \$4,306,500 \text{ FF}$$

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.

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$\$4,306,500 + \$10,000,000 = \$14,306,500$  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.

$\$14,306,500 / 12 \text{ months} \times 9 \text{ months} = \$10,729,875$  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:  $\$10,729,875 \times 95\% = \$10,193,000$  FF (Rounded)

13. Payments made in FY 2014-15 are estimated to be:

FY 2014-15:  $\$10,729,875 \times 5\% = \$536,000$  FF (Rounded)

	<u>TF</u>	<u>FF</u>
<b>FY 2013-14</b>	<b>\$10,193,000</b>	<b>\$10,193,000</b>
<b>FY 2014-15</b>	<b>\$536,000</b>	<b>\$536,000</b>

**Funding:**

100% Health Care Support Fund (4260-601-7503)

**MH/UCD—HEALTH CARE COVERAGE INITIATIVE**

REGULAR POLICY CHANGE NUMBER: 102  
 IMPLEMENTATION DATE: 9/2007  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1154

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>County/Agency</b>	<b>Annual Allocations</b>
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
<b>Total</b>	<b>\$180,000</b>

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)

<b>FY 2013-14</b>	<b>TF</b>	<b>FFP</b>	<b>CPE*</b>
2008-09	\$4,509	\$4,509	\$4,509
2009-10	\$5,104	\$5,104	\$5,104
<b>Total**</b>	<b>\$9,613</b>	<b>\$9,613</b>	<b>\$9,613</b>

\*Not included in TF.

\*\*Amounts may differ due to rounding.

**Funding:**

Health Care Support Fund (4260-601-7503)

**MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT**

REGULAR POLICY CHANGE NUMBER: 103  
 IMPLEMENTATION DATE: 7/2005  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1076

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>FY 2013-14</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>
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
<b>Cash Expenditures in FY 2013-14</b>	<b>\$8,510,000</b>	<b>\$4,255,000</b>	<b>\$4,255,000</b>
FY 2013-14 Ending Balance	\$0	\$0	\$0
<b>FY 2014-15</b>			
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
<b>Cash Expenditures in FY 2014-15</b>	<b>\$3,802,000</b>	<b>\$1,901,000</b>	<b>\$1,901,000</b>
FY 2014-15 Ending Balance	\$0	\$0	\$0

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)		
<u>Demonstration Year</u>	<u>State-Only Funded Programs</u>	<u>Due to DPHs and SLAMSP</u>
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)		
<u>Demonstration Year</u>	<u>FY 2013-14 FF</u>	<u>FY 2014-15 FF</u>
2005-06	\$1,949	
2006-07		\$35,917
<b>Total</b>	<b>\$1,949</b>	<b>\$35,917</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

	<b>FF</b>
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
<b>FY 2013-14</b>	
DSHP-BTR (DY 2013-14)	\$18,932,000
DY 2010-11 Final Reconciliation	\$395,000
<b>Total</b>	<b>\$19,327,000</b>
<b>FY 2014-15</b>	
DSHP-BTR (DY 2014-15)	\$18,932,000
DY 2011-12 Final Reconciliation	\$1,186,000
<b>Total</b>	<b>\$20,118,000</b>

**Funding:**

100% Health Care Support Fund (4260-601-7503)  
100% GF (4260-101-0001)

**MH/UCD & BTR—BCCTP**

REGULAR POLICY CHANGE NUMBER: 106  
 IMPLEMENTATION DATE: 9/2005  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1084

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

	<b>FF</b>
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
<b>FY 2013-14</b>	
DSHP-BTR (DY 2013-14)	\$1,915,000
DY 2010-11 Final Reconciliation	(\$129,000)
<b>Total</b>	<b>\$1,786,000</b>
<b>FY 2014-15</b>	
DSHP-BTR (DY 2014-15)	\$1,915,000
DY 2011-12 Final Reconciliation	\$264,000
<b>Total</b>	<b>\$2,179,000</b>

**MH/UCD & BTR—BCCTP**  
**REGULAR POLICY CHANGE NUMBER: 106**

**Funding:**

100% Health Care Support Fund (4260-601-7503)

100% GF (4260-101-0001)

**MH/UCD & BTR—DPH INTERIM RATE**

REGULAR POLICY CHANGE NUMBER: 107  
 IMPLEMENTATION DATE: 7/2005  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1161

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 SPSP 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.

**MH/UCD & BTR—DPH INTERIM RATE**

REGULAR POLICY CHANGE NUMBER: 107

**Methodology:**

1. The funding adjustment is estimated at:

(Dollars in Thousands)	<u>Expenditures</u>	<u>GF to FF shift</u>
<b>FY 2013-14</b>	<b>\$882,870</b>	<b>\$441,435</b>
<b>FY 2014-15</b>	<b>\$982,784</b>	<b>\$491,392</b>

**Funding:**

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

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

## BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 108  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1697

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

<b>FY 2013-14</b>	<b>FF</b>	<b>GF</b>
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
<b>Amount to SNCP-DSHPs</b>	<b>\$30.75</b>	<b>(\$30.75)</b>

**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

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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.

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CMHS	\$0	(\$28,925)	\$28,925
Final Reconciliation (EAPC & ADAP)	\$0	\$8,163	(\$8,163)
<b>Total</b>	<b>\$0</b>	<b>(\$20,762)</b>	<b>\$20,762</b>

**Funding:**

100% GF (4260-101-0001)

100% Health Care Support Fund (4260-601-7503)

## PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS

REGULAR POLICY CHANGE NUMBER: 111  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1786

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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.

## 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

## BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 112  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1694

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)		
<b>FY 2013-14</b>	<b>FF</b>	<b>GF</b>
<b>HCCI Rollover</b>		
DY 2012-13	(\$48.50)	\$0.00
DY 2013-14	(\$13.00)	\$0.00
<b>Total</b>	<b>(\$61.50)</b>	<b>\$0.00</b>
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)

## DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 113  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1708

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:
 
$$(\$171,541,000 / 12 \times 6 \text{ months}) - (\$166,060,000 / 12 \times 6 \text{ months}) = \$2,740,500 \text{ TF } (\$1,370,250 \text{ GF})$$
6. Private hospital savings in FY 2013-14 are estimated to be:
 
$$\$3,217,878,000 - \$3,115,067,000 = \$102,811,000 \text{ TF } (\$51,405,500 \text{ GF})$$
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 - \$166,060,000 = \$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)	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2013-14 Annual</b>			
Private FFS	(\$102,811)	(\$51,406)	(\$51,405)
NDPH FFS	(\$2,741)	(\$1,371)	(\$1,370)
<b>Total savings</b>	<b>(\$105,552)</b>	<b>(\$52,777)</b>	<b>(\$52,775)</b>

(Dollars in Thousands)	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2014-15 Annual</b>			
Private FFS	(\$225,606)	(\$112,803)	(\$112,803)
NDPH FFS	(\$12,027)	(\$6,014)	(\$6,013)
<b>Total savings</b>	<b>(\$237,633)</b>	<b>(\$118,817)</b>	<b>(\$118,816)</b>

**Funding:**

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

## MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 117  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1781

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)	<u>MCO Tax</u>	<u>FFP</u>	<u>TF</u>
<b>FY 2013-14</b>	<b>\$345,594</b>	<b>\$438,225</b>	<b>\$783,819</b>
<b>FY 2014-15</b>	<b>\$516,786</b>	<b>\$735,874</b>	<b>\$1,252,660</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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**

	<b>IGT*</b>	<b>Regular FFP</b>	<b>T21 FFP</b>	<b>Family Planning FFP</b>	<b>Total FFP</b>	<b>TF</b>
<b>Total</b>	<b>\$355,300</b>	<b>\$338,672</b>	<b>\$25,800</b>	<b>\$24,622</b>	<b>\$389,094</b>	<b>\$744,394</b>

**FY 2014-15**

	<b>IGT*</b>	<b>Regular FFP</b>	<b>T21 FFP</b>	<b>Family Planning FFP</b>	<b>Total FFP</b>	<b>TF</b>
<b>Total</b>	<b>\$391,449</b>	<b>\$373,129</b>	<b>\$28,425</b>	<b>\$27,127</b>	<b>\$428,681</b>	<b>\$820,130</b>

## 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)\*

## TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 119  
 IMPLEMENTATION DATE: 4/2014  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1766

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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.

**TRANSITION OF DUAL ELIGIBLES-MANAGED CARE  
PAYMENTS  
REGULAR POLICY CHANGE NUMBER: 119**

(Dollars in Thousands)

FY 2013-14	TF	GF	FFP	Reimburse ment
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
<b>Total</b>	<b>\$125,278</b>	<b>\$61,273</b>	<b>\$64,005</b>	<b>\$0</b>
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
<b>Total</b>	<b>(\$140,711)</b>	<b>(\$70,356)</b>	<b>(\$70,355)</b>	<b>\$0</b>
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
<b>Total of CCI PCs including pass through</b>	<b>\$23,211</b>	<b>(\$25,350)</b>	<b>(\$18,917)</b>	<b>\$67,478</b>

(Dollars in Thousands)

FY 2014-15	TF	GF	FFP	Reimburse ment
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
<b>Total</b>	<b>\$5,706,904</b>	<b>\$2,804,982</b>	<b>\$2,901,922</b>	<b>\$0</b>
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
<b>Total</b>	<b>(\$3,788,843)</b>	<b>(\$1,894,422)</b>	<b>(\$1,894,421)</b>	<b>\$0</b>
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
<b>Total of CCI PCs including pass through</b>	<b>\$2,844,173</b>	<b>\$172,905</b>	<b>\$272,829</b>	<b>\$2,398,440</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>FY 2013-14</b>			
Year 1 (amended)	\$21,919	\$21,919	\$43,838
Year 2	\$199,855	\$199,855	\$399,710
<b>Total</b>	<b>\$221,774</b>	<b>\$221,774</b>	<b>\$443,548</b>
<b>FY 2014-15</b>	<b>\$199,855</b>	<b>\$199,855</b>	<b>\$399,710</b>

**Funding:**

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

Reimbursement GF (4260-610-0995)

## EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 121  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1652

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)	<u>Gross Premium Tax</u>	<u>FFP</u>	<u>TF</u>
<b>FY 2013-14</b>	\$191,720	\$191,721	<b>\$338,441</b>

**Funding:**

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

## TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 123  
 IMPLEMENTATION DATE: 4/2014  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1653

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimbursement</b>
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
<b>Transfer of IHSS Costs to CDSS (PC 123)</b>	<b>\$45,505</b>	<b>\$0</b>	<b>\$0</b>	<b>\$45,505</b>
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

**TRANSFER OF IHSS COSTS TO CDSS**

REGULAR POLICY CHANGE NUMBER: 123

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimbursement</b>
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
<b>Transfer of IHSS Costs to CDSS (PC 123)</b>	<b>\$1,615,660</b>	<b>\$0</b>	<b>\$0</b>	<b>\$1,615,660</b>
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)

## RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 124  
 IMPLEMENTATION DATE: 10/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1788

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>2011-12 Retro Rate Adjustments</b>	<b>2012-13 Retro Rate Adjustments</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total</b>	<b>\$106,752</b>	<b>\$232,058</b>	<b>\$338,810</b>	<b>\$169,405</b>	<b>\$169,405</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<b>FY 2013-14</b>	
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)
<b>FY 2013-14 Cost</b>	<b>\$21,097,000</b>

<b>FY 2014-15</b>	
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)
<b>FY 2014-15 Savings</b>	<b>(\$16,426,000)</b>

### Funding:

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

## INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 128  
 IMPLEMENTATION DATE: 11/2009  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1455

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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:

	<b>2013-14</b>
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
<b>Total</b>	<b>\$8,862,000</b>

## NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER: 131  
 IMPLEMENTATION DATE: 7/1998  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 95

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

## CAPITATED RATE ADJUSTMENT FOR FY 2014-15

REGULAR POLICY CHANGE NUMBER: 132  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1338

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**CAPITATED RATE ADJUSTMENT FOR FY 2014-15**

REGULAR POLICY CHANGE NUMBER: 132

(Rounded)	<b>Cost by Plan</b>	<b>Rate Adjustment</b>	<b>Rate Increase</b>
COHS	\$3,607,617,000	3.63%	<b>\$130,956,000</b>
Two Plan	\$7,847,249,000	3.63%	<b>\$284,855,000</b>
GMC	\$1,357,157,000	3.63%	<b>\$49,265,000</b>
AHF	\$9,263,000	3.63%	<b>\$336,000</b>
<b>Total</b>	<b>\$12,821,286,000</b>	<b>3.63%</b>	<b>\$465,412,000</b>

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Funding:**

(In Thousands)	<b>COHS</b>	<b>Two Plan</b>	<b>GMC</b>	<b>AHF</b>	<b>Total</b>
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
<b>Total FFP</b>	<b>\$65,712</b>	<b>\$143,000</b>	<b>\$24,713</b>	<b>\$168</b>	<b>\$233,593</b>
<b>Total GF</b>	<b>\$65,243</b>	<b>\$141,855</b>	<b>\$24,552</b>	<b>\$168</b>	<b>\$231,818</b>
<b>Total</b>	<b>\$130,955</b>	<b>\$284,855</b>	<b>\$49,265</b>	<b>\$336</b>	<b>\$465,411</b>

## FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 133  
 IMPLEMENTATION DATE: 2/2011  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1586

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

### DESCRIPTION

**Purpose:**

This policy change estimates 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.

	<b>FY 2013-14</b>
Total Gross Premium Tax	\$5,557,000
GF	(\$5,557,000)
<b>Total</b>	<b>\$0</b>

**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

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

**DESCRIPTION****\*\*\*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.

**EXTEND GROSS PREMIUM TAX**

REGULAR POLICY CHANGE NUMBER: 134

The gross premium tax fund transfers to the GF are expected to be:

<b>FY 2013-14</b>	<b>GF</b>	<b>Gross Premium Tax</b>	<b>TF</b>
<b>Gross Premium Tax</b>	\$ (191,721,000)	\$ 191,721,000	\$ 0
<b>Amount to MRMIB</b>	\$ 128,102,000	\$ (128,102,000)	\$ 0
<b>Total</b>	\$ (63,619,000)	\$31,809,000	\$ 0

**Funding:**

100% State GF (4260-101-0001)

3156 Gross Premium Tax (Non-GF) (4260-601-3156)

## MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 135  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1601

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

### DESCRIPTION

#### Purpose

This policy change estimates the 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.

**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.

<b>(In Thousands)</b>	<b>IGT amount subject to the fee</b>	<b>20% Admin. &amp; Processing Fee</b>	<b>Support Cost Reimbursement to GF</b>	<b>Local Assistance Reimbursement to GF</b>
<b>FY 2013-14</b>	\$ 355,299	\$ 71,060 -	\$ 251 =	<b>\$ 70,809</b>
<b>FY 2014-15</b>	\$ 391,448	\$ 78,290 -	\$ 251 =	<b>\$ 78,039</b>

**Funding:**

100% State GF (4260-101-0001)  
Reimbursement (4260-610-0995)

## GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 136  
 IMPLEMENTATION DATE: 5/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1605

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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.

	<b>FY 2013-14</b>	<b>FY 2014-15</b>
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)
<b>Net Impact</b>	<b>\$ 0</b>	<b>\$ 0</b>

**Funding:**

Reimbursement (4260-610-0995)  
100% State GF (4260-101-1001)

## EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 137  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1655

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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.

**EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT**

REGULAR POLICY CHANGE NUMBER: 137

The gross premium tax fund transfers to the GF are expected to be:

	<u>GF</u>	<u>Gross Premium Tax</u>	<u>TF</u>
<b>FY 2013-14</b>	\$ (191,721,000)	\$ 191,721,000	<b>\$ 0</b>

**Funding:**

100% State GF (4260-101-0001)

3156 Gross Premium Tax (Non-GF) (4260-601-3156)

## FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 138  
 IMPLEMENTATION DATE: 7/2005  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1082

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

### DESCRIPTION

**Purpose:**

This policy change 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.

**FFS COSTS FOR MANAGED CARE ENROLLEES**

REGULAR POLICY CHANGE NUMBER: 138

**Methodology:**

In Fiscal Year 2012-2013 FFS payments for managed care enrollees totaled:

	<b>Expenditures by Aid Category</b>		
	<b>Other</b>	<b>CCS/GHPP</b>	<b>Total</b>
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
<b>Totals</b>	<b>\$939,061,000</b>	<b>\$1,191,559,000</b>	<b>\$2,130,620,000</b>

**Funding:**

Not Applicable

## MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 139  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1782

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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:**

- Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.
- 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:

	<u>GF</u>	<u>MCO Tax</u>	<u>TF</u>
<b>FY 2013-14</b>	\$ (260,111,000)	\$ 260,111,000	<b>\$ 0</b>
<b>FY 2014-15</b>	\$ (476,655,000)	\$ 476,655,000	<b>\$ 0</b>

**Funding:**

100% State GF (4260-101-0001)

3156 Gross Premium Tax (Non-GF) (4260-601-3156)

## MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 140  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1783

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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:

	<u>GF</u>	<u>MCO Tax</u>	<u>TF</u>
<b>FY 2013-14</b>	\$ (256,450,000)	\$ 256,450,000	<b>\$ 0</b>
<b>FY 2014-15</b>	\$ (462,329,000)	\$ 462,329,000	<b>\$ 0</b>

**Funding:**

100% State GF (4260-101-0001)

3156 Gross Premium Tax (Non-GF) (4260-601-3156)

## SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 141  
 IMPLEMENTATION DATE: 1/2015  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 1749

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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.

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Managed Care</b>	<b>SCAN</b>	<b>Total</b>
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
<b>Total</b>	<b>48,880</b>	<b>\$19,761,000</b>	<b>(\$19,761,000)</b>	<b>\$0</b>

**Funding:**

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

## DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 142  
 IMPLEMENTATION DATE: 10/2013  
 ANALYST: Candace Epstein  
 FISCAL REFERENCE NUMBER: 1482

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:	$3,430 \times \$352.33 \times .75 = \$ 906,000$
Napa County:	$1,718 \times \$843.95 \times .75 = \$1,087,000$
Yolo County:	$1,880 \times \$605.86 \times .75 = \$ 854,000$

$\$906,000 + \$1,087,000 + \$854,000 = \$2,847,000$

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

<b>FY 2013-14</b>	\$2,847,000	FFS cost
	<u>(\$2,847,000)</u>	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.

	<b>FY 2013-14</b>
Managed Care Savings	<u>(\$2,847,000)</u>
FFS Cost	\$2,847,000
FFS Payment Lag	0.6138
Lagged FFS Costs	<u>\$1,747,000</u>
Net costs (Rounded)	<b>(\$1,100,000)</b>

**Funding:**

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

## TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 143  
 IMPLEMENTATION DATE: 6/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1641

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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.

**TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE****REGULAR POLICY CHANGE NUMBER: 143**

(In Thousands)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimbursement</b>
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
<b>Total</b>	<b>\$125,278</b>	<b>\$61,273</b>	<b>\$64,005</b>	<b>\$0</b>
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
<b>Total</b>	<b>(\$140,711)</b>	<b>(\$70,356)</b>	<b>(\$70,355)</b>	<b>\$0</b>
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
<b>Total of CCI PCs including pass through</b>	<b>\$23,211</b>	<b>(\$25,350)</b>	<b>(\$18,917)</b>	<b>\$67,478</b>

(In Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimbursement</b>
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
<b>Total</b>	<b>\$5,706,904</b>	<b>\$2,804,982</b>	<b>\$2,901,922</b>	<b>\$0</b>
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
<b>Total</b>	<b>(\$3,788,843)</b>	<b>(\$1,894,422)</b>	<b>(\$1,894,421)</b>	<b>\$0</b>
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
<b>Total of CCI PCs including pass through</b>	<b>\$2,844,173</b>	<b>\$172,905</b>	<b>\$272,829</b>	<b>\$2,398,440</b>

**Funding:**

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

## FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 144  
 IMPLEMENTATION DATE: 7/2008  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1329

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>Total</b>	<b>\$278,268</b>	<b>\$207,969</b>

**Funding:**

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

## AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 145  
 IMPLEMENTATION DATE: 2/2014  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1508

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS	\$35,447	\$17,724	\$17,724
Retroactive Payments-FFS	\$42,536	\$21,268	\$21,268
<b>Total*</b>	<b>\$77,983</b>	<b>\$38,992</b>	<b>\$38,992</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FFS	\$165,396	\$98,026	\$98,026
Managed Care	\$34,690	\$20,388	\$20,388
<b>Total*</b>	<b>\$200,086</b>	<b>\$118,414</b>	<b>\$118,414</b>

**Funding:**

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

## QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 146  
 IMPLEMENTATION DATE: 4/2014  
 ANALYST: Jennifer Hsu  
 FISCAL REFERENCE NUMBER: 1563

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**QUALITY AND ACCOUNTABILITY SUPPLEMENTAL  
PAYMENTS**  
REGULAR POLICY CHANGE NUMBER: 146

**Methodology:**

- Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.
- 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

- 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.
- Estimated CDPH administrative costs are \$2,780,000 in FY 2013-14 and \$2,533,000 in FY 2014-15.
- 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
<b>FY 2013-14</b>				
Supplemental Payments***	\$40,673	\$0	\$20,336	\$20,336
Transfer from GF* to Special Fund**	\$0	\$24,552	(\$24,552)	\$0
<b>Total</b>	<b>\$40,673</b>	<b>\$24,552</b>	<b>(\$4,216)</b>	<b>\$20,336</b>
<b>FY 2014-15</b>				
Supplemental Payments***	\$42,657	\$0	\$21,328	\$21,328
Transfer from GF* to Special Fund**	\$0	\$25,161	(\$25,161)	\$0
<b>Total</b>	<b>\$42,657</b>	<b>\$25,161</b>	<b>(\$3,833)</b>	<b>\$21,328</b>

**Funding:**

100% GF (4260-605-0001)\*

SNF Quality &amp; Accountability (less funded by GF) (4260-698-3167)\*\*

SNF Quality &amp; Accountability (4260-605-3167)\*\*\*

Title XIX FFP (4260-101-0890)\*\*\*

## AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 147  
 IMPLEMENTATION DATE: 11/2012  
 ANALYST: Jennifer Hsu  
 FISCAL REFERENCE NUMBER: 1612

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

$\$7,641,000 \times 20\% = \$1,528,000$  (GF offset)

$\$7,641,000 - \$1,528,000 = \$6,113,000 \times 2 = \$12,226,000$  (\$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:

	<b>EMATA Fund</b>	<b>GF Offset (20%)</b>	<b>Available for Rate Augmentation</b>
<b>FY 2013-14</b>			
2012-13	\$4,890,000	\$978,000	\$3,912,000
2013-14	\$10,246,000	\$2,049,200	\$8,196,800
<b>Total</b>	<b>\$15,136,000</b>	<b>\$3,027,200</b>	<b>\$12,108,800</b>
<b>FY 2014-15</b>	<b>\$10,246,000</b>	<b>\$2,049,200</b>	<b>\$8,196,800</b>

5. The estimated payments on a cash basis are:

**AIR AMBULANCE MEDICAL TRANSPORTATION**

REGULAR POLICY CHANGE NUMBER: 147

(Dollars in  
Thousands)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>EMATA</b>	<b>FFP</b>
GF Offset	\$0	(\$3,027)	\$3,027	
Fee For Services	\$18,162		\$9,081	\$9,081
Managed Care	\$6,054		\$3,027	\$3,027
<b>Total</b>	<b>\$24,216</b>	<b>(\$3,027)</b>	<b>\$15,135</b>	<b>\$12,108</b>
<b>FY 2014-15</b>				
GF Offset	\$0	(\$2,049)	\$2,049	
Fee For Services	\$12,295		\$6,148	\$6,147
Managed Care	\$4,099		\$2,050	\$2,049
<b>Total</b>	<b>\$16,394</b>	<b>(\$2,049)</b>	<b>\$10,247</b>	<b>\$8,196</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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 65<sup>th</sup> percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65<sup>th</sup> 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.

## LTC RATE ADJUSTMENT

### REGULAR POLICY CHANGE NUMBER: 148

(Dollars in Thousands)

<b>Fee-for-Service</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
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
<b>Total Cost</b>	<b>\$19,783</b>	<b>\$108,753</b>

**Funding:**

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

## ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 149  
 IMPLEMENTATION DATE: 10/2005  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 88

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 1<sup>st</sup> 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		<b>2013 Visits</b>
10,179,009	3.45%	10,530,656
2013 Visits		<b>2014 Visits</b>
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	$\$142.50 \times (1+0.6\%) = \$143.36$
2014	\$143.36	$\$143.64 \times (1+0.8\%) = \$144.50$
2015	\$144.50	$\$144.79 \times (1+0.8\%) = \$145.66$

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)	
	TF	GF
<b>FY 2013-14</b>		
2012 MEI Increase	\$56,595	\$28,298
2013 MEI Increase	\$5,065	\$2,533
<b>Total</b>	<b>\$61,660</b>	<b>\$30,831</b>
<b>FY 2014-15</b>		
2013 MEI Increase	\$9,004	\$4,502
2014 MEI Increase	\$6,819	\$3,410
<b>Total</b>	<b>\$15,883</b>	<b>\$7,912</b>

**Funding:**

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

## HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150  
 IMPLEMENTATION DATE: 10/2006  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 96

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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 65<sup>th</sup> percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65<sup>th</sup> 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
<b>TOTAL*</b>	\$5,732	\$12,545

#### Funding:

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

\*Amounts may differ due to rounding.

## LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 151  
 IMPLEMENTATION DATE: 8/2013  
 ANALYST: Jennifer Hsu  
 FISCAL REFERENCE NUMBER: 1784

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

### DESCRIPTION

**Purpose:**

This policy change 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.

**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:

$\$439,445,000 \times (1+7.04\%) = \mathbf{\$470,374,000}$

(In Thousands)

	<u>TF</u>	<u>GF</u>	<u>LTCQAF</u>
<b>FY 2013-14</b>	<b>\$0</b>	<b>(\$439,445)</b>	<b>\$439,445</b>
<b>FY 2014-15</b>	<b>\$0</b>	<b>(\$470,374)</b>	<b>\$470,374</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 152

**Funding:**

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

## DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 153  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1185

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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.

**DENTAL RETROACTIVE RATE CHANGES**

REGULAR POLICY CHANGE NUMBER: 153

	<u>Existing Rate</u>	<u>New Rate</u>	<u>Change</u>	<u>Eligible Months</u>	<u>Dental Retro Rate Adjustment</u>
GMC Jan-Dec 2012					
<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 Jan-Dec 2012					
<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)
<b>Total FY 2013-14</b>					<b>(\$4,782,000)</b>
<b>Total GF FY 2013-14</b>					<b>(\$2,391,000)</b>

**Funding:**

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

## LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 154  
 IMPLEMENTATION DATE: 11/2013  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1703

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
2013-14 Savings	\$6,567	\$3,283	\$3,283
Retroactive Savings	\$3,283	\$1,642	\$1,642
<b>Total*</b>	<b>\$9,850</b>	<b>\$4,925</b>	<b>\$4,925</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
2014-15 Savings	\$9,850	\$4,925	\$4,925
Retroactive Savings	\$4,925	\$2,463	\$2,463
<b>Total*</b>	<b>\$14,775</b>	<b>\$7,388</b>	<b>\$7,388</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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, 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:

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.

<u>Facility Type</u>	<u>Payment Reduction Implementation Date</u>	<u>Total Months of Retroactive Period</u>	<u>Recoupment Start Date</u>	<u>Total Months to Recoup</u>
ICF/DDs	11/1/2013	N/A	N/A	N/A
NF-As	7/1/2012	13	9/1/2012	24
	<u>Payment Reduction Exempt Effective Date</u>			
<b>DP/NF-Bs</b>				
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.

		<u>FY 2013-14</u>	<u>Total Fund FY 2014-15</u>	<u>Annual</u>
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)
<b>Grand Total</b>		<b>(\$13,035,000)</b>	<b>(\$34,256,000)</b>	

**Funding:**

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

## REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 156  
 IMPLEMENTATION DATE: 12/2013  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1505

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
2013-14 Savings	(\$23,119)	(\$11,560)	(\$11,560)
Recoupment of Retro Savings	(\$12,356)	(\$6,178)	(\$6,178)
<b>Total*</b>	<b>(\$35,475)</b>	<b>(\$17,737)</b>	<b>(\$17,737)</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
2014-15 Savings	(\$39,633)	(\$19,816)	(\$19,816)
Recoupment of Retro Savings	(\$21,181)	(\$10,590)	(\$10,590)
<b>Total*</b>	<b>(\$60,814)</b>	<b>(\$30,407)</b>	<b>(\$30,407)</b>

**Funding:**

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

\*Amounts may differ due to rounding.

## 10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157  
 IMPLEMENTATION DATE: 12/2011  
 ANALYST: Jennifer Hsu  
 FISCAL REFERENCE NUMBER: 1580

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.
    - 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.
    - 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.
    - 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.

<u>Provider Type</u>	<u>Payment Reduction Effective Date</u>	<u>Payment Reduction Implementation Date</u>	<u>Total Months of Retroactive Period</u>	<u>Recoupment Start Date</u>	<u>Total Months to Recoup</u>
<b>Phase I</b>	6/1/2011	12/20/2011	7	6/29/2012	24
<b>Phase II</b>					
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
<b>Phase III (CHDP)</b>	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.

**10% PROVIDER PAYMENT REDUCTION**

REGULAR POLICY CHANGE NUMBER: 157

(Dollars In Thousands)		Total Fund		Annual
		FY 2013-14	FY 2014-15	
<b>Phase I</b>	FFS	(\$55,209)	(\$56,137)	(\$61,951)
	FFS Retro	(\$14,377)	\$0	(\$14,377)
	<b>Phase I Total</b>	(\$69,586)	(\$56,137)	
<b>Phase II</b>				
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)
	<b>Phase II Total</b>	(\$283,723)	(\$680,012)	
<b>Phase III (CHDP)</b>				
	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)
	<b>Grand Total</b>	<b>(\$312,677)</b>	<b>(\$531,384)</b>	

**Funding:**

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

## HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 158  
 IMPLEMENTATION DATE: 9/2012  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1475

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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, Statutes 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:

<b>FY 2013-14</b>	<b>TF</b>	<b>SF(HQARF)</b>	<b>FF</b>	<b>ARRA</b>
<b>AB 1383**</b>	\$29,376,000	\$11,283,000	\$14,688,000	\$3,405,000
<b>SB 90*</b>	\$1,217,000	\$525,000	\$609,000	\$84,000
<b>SB 335**</b>	\$4,179,087,000	\$2,103,147,000	\$2,075,940,000	
<b>Total</b>	<b>\$4,209,680,000</b>	<b>\$2,114,955,000</b>	<b>\$2,091,237,000</b>	<b>\$3,489,000</b>

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)

## EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159  
 IMPLEMENTATION DATE: 4/2014  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1761

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)	<u>TF</u>	<u>SF(HQARF)</u>	<u>FF</u>
<b>FY 2013-14</b>	<b>\$2,261,177</b>	<b>\$1,137,338</b>	<b>\$1,123,839</b>
<b>FY 2014-15</b>	<b>\$7,024,244</b>	<b>\$3,539,684</b>	<b>\$3,484,560</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

<b>FY 2013-14</b>	<b>TF</b>	<b>ARRA</b>	<b>FFP</b>
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
<b>Total FY 2013-14</b>	<b>\$455,989</b>	<b>\$30,442</b>	<b>\$425,547</b>

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>ARRA</b>	<b>FFP</b>
FY 2013-14	<b>\$66,000</b>	\$0	<b>\$66,000</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:**

- 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.
- Funding for services provided between January 30, 2010 through June 30, 2011 will be reimbursed at the appropriate FMAP rate.
- Payments will begin in January 2014.

The estimated payments on a cash basis are:

(Dollars In Thousands)

<b>FY 2013-14</b>		<b>CPE</b>	<b>Regular FFP</b>	<b>ARRA</b>	<b>Total FFP</b>
	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
	<b>Total</b>	<b>\$350,000</b>	<b>\$175,000</b>	<b>\$15,500</b>	<b>\$190,500</b>
<b>FY 2014-15</b>		<b>CPE</b>	<b>Regular FFP</b>	<b>ARRA</b>	<b>Total FFP</b>
	<b>Total</b> FY 2013-14	\$100,000	\$50,000	\$0	\$50,000

**Funding:**

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

## HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 162  
 IMPLEMENTATION DATE: 4/2004  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 78

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

	<b>Regular FFP</b>	<b>FY 2013-14 ARRA</b>	<b>Total FFP</b>
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
	<u>\$178,804,000</u>	<u>\$370,000</u>	<u><b>\$179,174,000</b></u>
	<b>Regular FFP</b>	<b>FY 2014-15 ARRA</b>	<b>Total FFP</b>
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
	<u>\$186,774,000</u>	<u>\$0</u>	<u><b>\$186,774,000</b></u>

**Funding:**

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

## NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 163  
 IMPLEMENTATION DATE: 10/2013  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1600

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

**NDPH IGT SUPPLEMENTAL PAYMENTS**

REGULAR POLICY CHANGE NUMBER: 163

(Dollars in Thousands)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF**</b>	<b>IGT*</b>	<b>FF</b>
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
<b>Total</b>	<b>\$140,000</b>	<b>(\$6,644)</b>	<b>\$76,644</b>	<b>\$70,000</b>
<b>FY 2014-15</b>				
Payments to NDPHs	\$70,000	\$0	\$35,000	\$35,000
Children's Services	\$0	(\$3,322)	\$3,322	\$0
<b>Total</b>	<b>\$70,000</b>	<b>(\$3,322)</b>	<b>\$38,322</b>	<b>\$35,000</b>

**Funding:**

50% Medi-Cal Inpatient Payment Adjustment (MIPA) Fund (4260-606-0834)\*

50% Title XIX FF (4260-101-0890)\*

100% GF (4260-101-0001)\*\*

## CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 164  
 IMPLEMENTATION DATE: 6/2002  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 86

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

<b>FY 2013-14</b>	<b>Total FFP</b>	<b>FFP</b>	<b>ARRA</b>
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	
<b>Total FY 2013-14</b>	<b>\$117,889,000</b>	<b>\$115,402,000</b>	<b>\$2,487,000</b>
<b>FY 2014-15</b>	<b>Total FFP</b>	<b>FFP</b>	<b>ARRA</b>
FY 2009-10 Reconciliation	\$2,420,000	\$1,964,000	\$456,000
FY 2013-14	\$41,238,000	\$41,238,000	
<b>Total FY 2014-15</b>	<b>\$43,658,000</b>	<b>\$43,202,000</b>	<b>\$456,000</b>

**Funding:**

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

## CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 165  
 IMPLEMENTATION DATE: 7/1991  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 82

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**CAPITAL PROJECT DEBT REIMBURSEMENT**

REGULAR POLICY CHANGE NUMBER: 165

**Methodology:**

(Dollars in Thousands)

**FY 2013-14**

	<b>TF</b>	<b>GF</b>	<b>FFP</b>
Hospitals	\$97,379	\$48,689	\$48,690
DP-NFs	\$19,808	\$0	\$19,808
<b>Total*</b>	<b>\$117,187</b>	<b>\$48,689</b>	<b>\$68,497</b>

**FY 2014-15**

	<b>TF</b>	<b>GF</b>	<b>FFP</b>
Hospitals	\$90,422	\$45,211	\$45,211
DP-NFs	\$20,435	\$0	\$20,435
<b>Total</b>	<b>\$110,857</b>	<b>\$45,211</b>	<b>\$65,646</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>Total FY 2013-14</b>	<b>\$100,000</b>	<b>\$50,000</b>	<b>\$50,000</b>

**FFP FOR LOCAL TRAUMA CENTERS**

REGULAR POLICY CHANGE NUMBER: 166

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>Special Deposit Fund</b>	<b>FFP</b>
FY 2014-15	<u>\$70,000</u>	<u>\$35,000</u>	<u>\$35,000</u>
<b>Total FY 2014-15</b>	<b>\$70,000</b>	<b>\$35,000</b>	<b>\$35,000</b>

**Funding Table:**

50% Local Trauma Centers Fund / 50% Title XIX FFP (4260-601-0942142) / (4260-101-0890)

## IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 167  
 IMPLEMENTATION DATE: 7/2006  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1158

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**IGT PAYMENTS FOR HOSPITAL SERVICES**

REGULAR POLICY CHANGE NUMBER: 167

(Dollars In Thousands)	<u>TF</u>	<u>IGT</u>	<u>FFP</u>
<b>FY 2013-14</b>	<b>\$15,000</b>	<b>\$7,500</b>	<b>\$7,500</b>
	<u>TF</u>	<u>IGT</u>	<u>FFP</u>
<b>FY 2014-15</b>	<b>\$15,000</b>	<b>\$7,500</b>	<b>\$7,500</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

	<u>TF</u>	<u>FF</u>	<u>GF</u>
FY 2013-14	\$10,000	\$5,000	\$5,000
FY 2014-15	\$10,000	\$5,000	\$5,000

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

	<u>TF</u>	<u>FF</u>	<u>GF</u>
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)

## STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170  
 IMPLEMENTATION DATE: 12/2010  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1616

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS**

REGULAR POLICY CHANGE NUMBER: 170

Program payment amounts are estimated to be:

(In Thousands)

**FY 2013-14**

State Veterans' Homes for FY 2012-13

State Veterans' Homes for FY 2013-14

**Total****FFP**

\$3,600

\$1,875

**\$5,475****FY 2014-15**

State Veterans' Homes for FY 2013-14

State Veterans' Homes for FY 2014-15

**Total**

\$1,875

\$1,925

**\$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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.
   
  

$$3,026 \text{ professionals} \times \$21,250 = \$64,302,500$$

$$2,795 \text{ professionals} \times \$8,500 = \$23,757,500$$

$$384 \text{ professionals} \times \$8,500 = \$3,264,000$$
  
  

$$12 \text{ hospitals} \times \$1,550,000 = \$18,600,000$$

$$124 \text{ hospitals} \times \$930,000 = \$115,320,000$$

$$49 \text{ hospitals} \times \$310,000 = \$15,190,000$$
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****FY 2013-14**

	<b>FF</b>
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
	<b>\$240,434,000</b>

**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
	<b>\$151,718,750</b>

**Funding:**

100% FFP (4260-101-0001)

## ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 178  
 IMPLEMENTATION DATE: 6/2011  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1232

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS**

REGULAR POLICY CHANGE NUMBER: 178

**Methodology:**

The following estimates have been provided by CDDS:

(In Thousands)

<b>CASH</b>			<b>FFP</b>	<b>FFP</b>	<b>Total*</b>	
<b>BASIS</b>	<b>TF</b>	<b>CDDS GF</b>	<b>Regular</b>	<b>ARRA</b>	<b>FFP</b>	<b>IA #</b>
<b>FY 2013-14</b>	\$254,998	\$121,754	\$127,499	\$5,745	<b>\$133,245</b>	07-65896
<b>FY 2014-15</b>	\$172,289	\$84,229	\$86,145	\$1,915	<b>\$88,060</b>	07-65896

**Funding:**

100% Title XIX (4260-101-0890)

\*Amounts may differ due to rounding.

## NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 183  
 IMPLEMENTATION DATE: 7/2008  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 1340

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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
<b>FY 2013-14</b>	<b>\$11,487</b>	<b>\$5,743</b>	<b>\$5,744</b>
<b>FY 2014-15</b>	<b>\$8,501</b>	<b>\$4,250</b>	<b>\$4,251</b>

**Funding:**

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

## CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 184  
 IMPLEMENTATION DATE: 2/2012  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1629

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)

<b>ICF-DD Admin Fee</b>	<b>QA Fee Reimbursements</b>	<b>Total Funds</b>	<b>CDDS GF</b>	<b>DHCS GF</b>	<b>FFP</b>
\$3,844	\$7,647	\$22,981	\$2,416	<b>\$8,740</b>	<b>\$11,825</b>

**FY 2014-15\*** (In Thousands)

<b>ICF-DD Admin Fee</b>	<b>QA Fee Reimbursements</b>	<b>Total Funds</b>	<b>CDDS GF</b>	<b>DHCS GF</b>	<b>FFP</b>
\$1,500	\$8,322	\$18,116	\$1,702	<b>\$6,481</b>	<b>\$9,934</b>

**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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
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
<b>Total for FY 2013-14</b>	<b>\$7,837,000</b>	<b>\$2,351,000</b>	<b>\$5,486,000</b>

**Funding:**

100% Title XIX (4260-101-0890)

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

## AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187  
 IMPLEMENTATION DATE: 9/2013  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 110

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 made 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 \$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.

<b>FY 2013-14</b>		<b>TF</b>	<b>GF</b>
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
	<b>Total</b>	<b>\$8,247,000</b>	<b>\$8,247,000</b>
 <b>FY 2014-15</b>		 <b>TF</b>	 <b>GF</b>
A-09-12-02077	FPACT-Drugs Review	<b>\$627,000</b>	<b>\$627,000</b>

**Funding:**

100% GF (4260-101-0001)

## INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 191  
 IMPLEMENTATION DATE: 4/1998  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 111

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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		<b>\$1,254</b>	<b>(\$9,436)</b>	<b>\$10,690</b>

**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		<b>\$2,180*</b>	<b>(\$9,436)</b>	<b>\$11,615</b>

\*Totals may differ due to rounding.

## CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 192  
 IMPLEMENTATION DATE: 1/2006  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1087

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

### DESCRIPTION

**Purpose:**

This policy change 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	<u>\$23,540,000</u>
Total CTPS/Prop. 99	\$82,591,000
GF	<u>(\$82,591,000)</u>
<b>Net Impact</b>	<b>\$0</b>

**FY 2014-15**

Hospital Services Account	\$72,435,000
Physicians' Services Account	\$105,000
Unallocated Account	<u>\$26,991,000</u>
Total CTPS/Prop. 99	\$99,531,000
GF	<u>(\$99,531,000)</u>
<b>Net Impact</b>	<b>\$0</b>

**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)

## ANTI-FRAUD ACTIVITIES

REGULAR POLICY CHANGE NUMBER: 193  
 IMPLEMENTATION DATE: 1/2012  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1474

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## **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

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

### DESCRIPTION

**Purpose:**

This policy change 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.

**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.

	<b>CLPP Fund</b>
<b>Total FY 2013-14</b>	<b>\$714,000</b>
<b>Total FY 2014-15</b>	<b>\$714,000</b>

**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

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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)	<u>Children's Health Care Coverage</u>
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)	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev Fund</u>
FY 2012-13	\$0	(\$134,250)	\$134,250
FY 2013-14	\$0	(\$310,000)	\$310,000
<b>FY 2013-14 Total</b>	<b>\$0</b>	<b>(\$444,250)</b>	<b>\$444,250</b>

**Funding:**

100% GF (4260-101-0001)

100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

## AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 196  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Jennifer Hsu  
 FISCAL REFERENCE NUMBER: 1656

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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.

## 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

## TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 197  
 IMPLEMENTATION DATE: 4/2014  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1654

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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 managed 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.

**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)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimbursement</b>
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
<b>Transfer of IHSS Costs to DHCS (PC 197)</b>	<b>\$0</b>	<b>(\$21,973)</b>	<b>\$0</b>	<b>\$21,973</b>
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

**TRANSFER OF IHSS COSTS TO DHCS**

REGULAR POLICY CHANGE NUMBER: 197

(In Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>Reimbursement</b>
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
<b>Transfer of IHSS Costs to DHCS (PC 197)</b>	<b>\$0</b>	<b>(\$782,780)</b>	<b>\$0</b>	<b>\$782,780</b>
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)

## EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 198  
 IMPLEMENTATION DATE: 6/2014  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1760

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

### DESCRIPTION

**Purpose:**

This policy change estimates the 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)

	<b>TF</b>	<b>GF</b>	<b>Hosp. QA Rev Fund</b>
<b>FY 2013-14</b>	<u>\$0</u>	<u>(\$155,000)</u>	<u>\$155,000</u>
<b>FY 2014-15</b>			
FY 2013-14	\$0	(\$155,000)	\$155,000
FY 2014-15	<u>\$0</u>	<u>(\$558,375)</u>	<u>\$558,375</u>
<b>Total</b>	<b>\$0</b>	<b>(\$713,375)</b>	<b>\$713,375</b>

**Funding:**

100% GF (4260-101-0001)

100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

## RECOVERY OF PCS/IHSS

REGULAR POLICY CHANGE NUMBER: 199  
 IMPLEMENTATION DATE: 1/2015  
 ANALYST: Raman Pabla  
 FISCAL REFERENCE NUMBER: 1816

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.  

$$\$10,745,092,000 \times 29.53\% = \$3,173,360,000$$
3. Of the \$10,745,092,000 Medi-Cal expenditures, the Department collected 0.49% for ER claims.  

$$\$10,745,092,000 \times 0.49\% = \$52,651,000$$
4. Assume the additional PCS/IHSS claims correlates to the percentage the Department collects in Medi-Cal ER claims.  

$$\$3,173,360,000 \times 0.49\% = \$15,549,000$$
5. Assume the Department will only recover 10% of the PCS/IHSS claims annually.  

$$\$15,549,000 \times 10\% = \$1,555,000$$
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.

	<b>FY 2014-15</b>	<b>Annually</b>
GF	(\$194,000)	(\$777,000)
FF	(\$195,000)	(\$778,000)
<b>Total</b>	<b>(\$389,000)</b>	(\$1,555,000)

**Funding:**

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

## MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 200  
 IMPLEMENTATION DATE: 10/2012  
 ANALYST: Raman Pabla  
 FISCAL REFERENCE NUMBER: 1587

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
<b>TOTALS</b>	<b>(\$4,000)</b>	<b>(\$3,800)</b>	<b>(\$200)</b>	<b>(\$2,400)</b>	<b>(\$2,280)</b>	<b>(\$120)</b>

**Funding:**

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

100% General Fund (4260-101-0001) \*

## IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER: 201  
 IMPLEMENTATION DATE: 8/2012  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 1746

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

## 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)

## ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 206  
 IMPLEMENTATION DATE: 4/2014  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1834

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

## ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 206

### Reason for Change from Prior Estimate:

New policy change

### Methodology:

- 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	<u>150,000</u>
d. Total	1,036,000

- 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
- 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
- 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.
- Based upon the above assumptions, total member months of new eligibles will be:

<u>Member Months</u>	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Adults	176,000	1,540,000
Children	<u>31,200</u>	<u>273,000</u>
Total	207,200	1,813,000

- 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:

<u>PMPM</u>	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Adults	\$391.41	\$429.71
Children	\$84.84	\$93.28

- Adults are assumed to qualify for ACA 100% federal funding.
- An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% funding, while the rest qualify for Title XIX 50% funding.

**ACA EXPRESS LANE ENROLLMENT**

REGULAR POLICY CHANGE NUMBER: 206

**Funding:**

	<b>Title XXI*</b>	<b>Title XIX**</b>	<b>ACA Title XIX***</b>	<b>Total</b>
<b>FY 2013-14</b>	<b>\$794,000</b>	<b>\$1,853,000</b>	<b>\$68,888,000</b>	<b>\$71,535,000</b>
<b>FY 2014-15</b>	<b>\$7,639,000</b>	<b>\$17,825,000</b>	<b>\$661,750,000</b>	<b>\$687,214,000</b>

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

\*\*Title XIX 50/50 (4260-101-0001/0890)

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

## DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER: 208  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1832

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

$$77,985 \times \$272.51 = \$21,252,000$$

5. An estimated 20% will be Title XXI Healthy Families.

$$\$21,252,000 \times 20\% = \$4,250,000$$

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.

$$\begin{aligned} 910,085 \times \$0.9427 &= \$ 858,000 \text{ ACSL} \\ 536,792 \times \$0.23 &= \$ 123,000 \text{ Postage/ mailing} \\ 536,792 \times \$0.04 &= \$ 22,000 \text{ Printing} \\ &\underline{\hspace{1.5cm}} \\ & \$1,003,000 \end{aligned}$$

7. The annualized impact based upon FY 2014-15 costs is:

$$\$21,252,000 \text{ increased benefits} + \$1,003,000 \text{ administrative cost} = \$22,255,000 \text{ Total}$$

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

<b>FY 2014-15</b>	<b>TF</b>	<b>Reimbursement</b>
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
<b>Total</b>	<b>\$ 17,467,000</b>	<b>\$ 8,098,000</b>

**Funding:**

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

Reimbursement GF (4260-610-0995)

## ACA EXPANSION-PREGNANCY ONLY

REGULAR POLICY CHANGE NUMBER: 210  
 IMPLEMENTATION DATE: 1/2015  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1794

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**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)	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2014-15 savings</b>	<b>(\$33,145)</b>	<b>(\$16,573)</b>	<b>(\$16,572)</b>

**Funding:**

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

## MCO SUPPLEMENTAL DRUG REBATE

REGULAR POLICY CHANGE NUMBER: 211  
 IMPLEMENTATION DATE: 4/2015  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1836

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

	<u>TF</u>	<u>FF</u>	<u>GF</u>
<b>FY 2014-15</b>	<b>(\$53,000)</b>	<b>(\$26,500)</b>	<b>(\$26,500)</b>

**Funding**

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

## AIM LINKED MOTHERS 200-300% FPL

REGULAR POLICY CHANGE NUMBER: 212  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1837

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

**AIM LINKED MOTHERS 200-300% FPL**

REGULAR POLICY CHANGE NUMBER: 212

(In Thousands)	<u>TF</u>	<u>SF</u>	<u>FF</u>
<b>FY 2014-15</b>	<b>\$128,655</b>	<b>\$57,459</b>	<b>\$71,196</b>

**Funding:**

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

**November 2013 Medi-Cal Estimate**

**COUNTY ADMINISTRATION  
FUNDING SUMMARY  
(Includes Other Administration)**

<b>FY 2013-2014 ESTIMATE:</b>	<b>Total Funds</b>	<b>Federal Funds</b>	<b>State Funds</b>
BASE	\$1,302,683,000	\$651,341,500	\$651,341,500
POLICY CHANGES	\$457,977,000	\$455,739,950	\$2,237,050
<b>SubTotal County Admin.</b>	<b>\$1,760,660,000</b>	<b>\$1,107,081,450</b>	<b>\$653,578,550</b>
OTHER ADMINISTRATION	\$1,861,825,000	\$1,691,616,700	\$170,208,300
<b>TOTAL CURRENT YEAR</b>	<b>\$3,622,485,000</b>	<b>\$2,798,698,150</b>	<b>\$823,786,850</b>

<b>FY 2014-2015 ESTIMATE:</b>	<b>Total Funds</b>	<b>Federal Funds</b>	<b>State Funds</b>
BASE	\$1,302,683,000	\$651,341,500	\$651,341,500
POLICY CHANGES	\$375,210,000	\$520,061,600	(\$144,851,600)
<b>SubTotal County Admin.</b>	<b>\$1,677,893,000</b>	<b>\$1,171,403,100</b>	<b>\$506,489,900</b>
OTHER ADMINISTRATION	\$1,684,019,000	\$1,512,722,150	\$171,296,850
<b>TOTAL BUDGET YEAR</b>	<b>\$3,361,912,000</b>	<b>\$2,684,125,250</b>	<b>\$677,786,750</b>

<b>Note:</b>			
C/Y Title XXI (Item 113) activities	\$26,500,000	\$13,250,000	\$13,250,000
B/Y Title XXI (Item 113) activities	\$26,500,000	\$13,250,000	\$13,250,000
C/Y HIPAA (Item 117) activities	\$116,617,000	\$81,211,000	\$35,406,000
B/Y HIPAA (Item 117) activities	\$95,652,000	\$66,553,000	\$29,099,000

**MEDI-CAL COUNTY ADMINISTRATION  
POLICY CHANGE SUMMARY  
FISCAL YEAR 2013-14**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGE	TOTAL STATE FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
<b>OTHER</b>							
1	COUNTY ADMINISTRATION BASE	\$0	\$0	\$1,302,683,000	\$0	\$1,302,683,000	\$651,341,500
2	SAWS	\$175,602,000	\$0	\$0	\$0	\$175,602,000	\$7,566,000
3	IMPLEMENTATION OF ACA	\$13,759,000	\$0	\$0	\$130,086,000	\$143,845,000	\$71,922,500
4	CalWORKs APPLICATIONS	\$0	\$0	\$64,896,000	\$0	\$64,896,000	\$32,448,000
5	TRANSITION OF HFP TO MEDI-CAL	\$0	\$0	\$0	\$54,363,000	\$54,363,000	\$19,027,050
6	FY 2013-14 COST OF DOING BUSINESS	\$0	\$0	\$30,813,000	\$0	\$30,813,000	\$15,406,500
7	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$26,037,000	\$26,037,000	\$2,308,000
8	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$99,000	\$0	\$0	\$0	\$99,000	\$99,000
11	SAVE	\$0	\$0	\$0	\$0	\$0	-\$3,500,000
13	PRIOR YEAR RECONCILIATIONS	-\$37,678,000	\$0	\$0	\$0	-\$37,678,000	-\$18,839,000
14	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	-\$124,201,000
	<b>OTHER SUBTOTAL</b>	<b>\$151,782,000</b>	<b>\$0</b>	<b>\$1,398,392,000</b>	<b>\$210,486,000</b>	<b>\$1,760,660,000</b>	<b>\$653,578,550</b>
	<b>GRAND TOTAL</b>	<b>\$151,782,000</b>	<b>\$0</b>	<b>\$1,398,392,000</b>	<b>\$210,486,000</b>	<b>\$1,760,660,000</b>	<b>\$653,578,550</b>

**MEDI-CAL COUNTY ADMINISTRATION  
POLICY CHANGE SUMMARY  
FISCAL YEAR 2014-15**

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES		ON-GOING CHANGES		TOTAL POLICY CHANGE	TOTAL STATE FUNDS
		PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
<b>OTHER</b>							
1	COUNTY ADMINISTRATION BASE	\$0	\$0	\$1,302,683,000	\$0	\$1,302,683,000	\$651,341,500
2	SAWS	\$155,135,000	\$0	\$0	\$0	\$155,135,000	\$7,566,000
3	IMPLEMENTATION OF ACA	\$0	\$0	\$0	\$130,086,000	\$130,086,000	\$65,043,000
4	CalWORKs APPLICATIONS	\$0	\$0	\$67,503,000	\$0	\$67,503,000	\$33,751,500
5	TRANSITION OF HFP TO MEDI-CAL	\$0	\$0	\$0	\$43,054,000	\$43,054,000	\$15,068,900
7	LOS ANGELES COUNTY HOSPITAL INTAKES	\$0	\$0	\$0	\$15,313,000	\$15,313,000	\$3,561,500
9	FY 2014-2015 COST OF DOING BUSINESS	\$0	\$0	\$20,218,000	\$0	\$20,218,000	\$10,109,000
11	SAVE	\$0	\$0	\$0	\$0	\$0	-\$3,500,000
12	REDUCTION TO COLA TO COUNTIES FOR FY 2014-15	\$0	\$0	-\$20,218,000	\$0	-\$20,218,000	-\$10,109,000
13	PRIOR YEAR RECONCILIATIONS	-\$35,881,000	\$0	\$0	\$0	-\$35,881,000	-\$17,940,500
14	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	\$0	\$0	-\$248,402,000
	<b>OTHER SUBTOTAL</b>	<b>\$119,254,000</b>	<b>\$0</b>	<b>\$1,370,186,000</b>	<b>\$188,453,000</b>	<b>\$1,677,893,000</b>	<b>\$506,489,900</b>
	<b>GRAND TOTAL</b>	<b>\$119,254,000</b>	<b>\$0</b>	<b>\$1,370,186,000</b>	<b>\$188,453,000</b>	<b>\$1,677,893,000</b>	<b>\$506,489,900</b>

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

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
		<b>OTHER</b>						
1	1	COUNTY ADMINISTRATION BASE	\$1,302,683,000	\$651,341,500	\$1,302,683,000	\$651,341,500	\$0	\$0
2	2	SAWS	\$167,378,000	\$7,566,000	\$175,602,000	\$7,566,000	\$8,224,000	\$0
3	4	CalWORKs APPLICATIONS	\$64,896,000	\$32,448,000	\$64,896,000	\$32,448,000	\$0	\$0
5	7	LOS ANGELES COUNTY HOSPITAL INTAKES	\$20,354,000	\$3,561,500	\$26,037,000	\$2,308,000	\$5,683,000	-\$1,253,500
7	5	TRANSITION OF HFP TO MEDI-CAL	\$33,716,000	\$11,800,600	\$54,363,000	\$19,027,050	\$20,647,000	\$7,226,450
9	6	FY 2013-14 COST OF DOING BUSINESS	\$30,813,000	\$15,406,500	\$30,813,000	\$15,406,500	\$0	\$0
10	11	SAVE	\$0	-\$3,500,000	\$0	-\$3,500,000	\$0	\$0
13	13	PRIOR YEAR RECONCILIATIONS	-\$70,000,000	-\$35,000,000	-\$37,678,000	-\$18,839,000	\$32,322,000	\$16,161,000
14	3	IMPLEMENTATION OF ACA	\$143,845,000	\$71,922,500	\$143,845,000	\$71,922,500	\$0	\$0
16	8	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$99,000	\$99,000	\$99,000	\$99,000	\$0	\$0
--	14	ENHANCED FEDERAL FUNDING	\$0	\$0	\$0	-\$124,201,000	\$0	-\$124,201,000
		<b>OTHER SUBTOTAL</b>	<b>\$1,693,784,000</b>	<b>\$755,645,600</b>	<b>\$1,760,660,000</b>	<b>\$653,578,550</b>	<b>\$66,876,000</b>	<b>-\$102,067,050</b>
		<b>COUNTY ADMINISTRATION GRAND TOTAL</b>	<b>\$1,693,784,000</b>	<b>\$755,645,600</b>	<b>\$1,760,660,000</b>	<b>\$653,578,550</b>	<b>\$66,876,000</b>	<b>-\$102,067,050</b>

Costs shown do not include percent reflected in base calculation.

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

NOV. PC#	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>OTHER</b>						
1	COUNTY ADMINISTRATION BASE	\$1,302,683,000	\$651,341,500	\$1,302,683,000	\$651,341,500	\$0	\$0
2	SAWS	\$175,602,000	\$7,566,000	\$155,135,000	\$7,566,000	-\$20,467,000	\$0
3	IMPLEMENTATION OF ACA	\$143,845,000	\$71,922,500	\$130,086,000	\$65,043,000	-\$13,759,000	-\$6,879,500
4	CalWORKs APPLICATIONS	\$64,896,000	\$32,448,000	\$67,503,000	\$33,751,500	\$2,607,000	\$1,303,500
5	TRANSITION OF HFP TO MEDI-CAL	\$54,363,000	\$19,027,050	\$43,054,000	\$15,068,900	-\$11,309,000	-\$3,958,150
6	FY 2013-14 COST OF DOING BUSINESS	\$30,813,000	\$15,406,500	\$0	\$0	-\$30,813,000	-\$15,406,500
7	LOS ANGELES COUNTY HOSPITAL INTAKES	\$26,037,000	\$2,308,000	\$15,313,000	\$3,561,500	-\$10,724,000	\$1,253,500
8	STATE-ONLY FORMER FOSTER CARE PROGRAM	\$99,000	\$99,000	\$0	\$0	-\$99,000	-\$99,000
9	FY 2014-2015 COST OF DOING BUSINESS	\$0	\$0	\$20,218,000	\$10,109,000	\$20,218,000	\$10,109,000
11	SAVE	\$0	-\$3,500,000	\$0	-\$3,500,000	\$0	\$0
12	REDUCTION TO COLA TO COUNTIES FOR FY 2014-15	\$0	\$0	-\$20,218,000	-\$10,109,000	-\$20,218,000	-\$10,109,000
13	PRIOR YEAR RECONCILIATIONS	-\$37,678,000	-\$18,839,000	-\$35,881,000	-\$17,940,500	\$1,797,000	\$898,500
14	ENHANCED FEDERAL FUNDING	\$0	-\$124,201,000	\$0	-\$248,402,000	\$0	-\$124,201,000
	<b>OTHER SUBTOTAL</b>	<b>\$1,760,660,000</b>	<b>\$653,578,550</b>	<b>\$1,677,893,000</b>	<b>\$506,489,900</b>	<b>-\$82,767,000</b>	<b>-\$147,088,650</b>
	<b>COUNTY ADMINISTRATION GRAND TOTAL</b>	<b>\$1,760,660,000</b>	<b>\$653,578,550</b>	<b>\$1,677,893,000</b>	<b>\$506,489,900</b>	<b>-\$82,767,000</b>	<b>-\$147,088,650</b>

Costs shown do not include percent reflected in base calculation.

**MEDI-CAL COUNTY ADMINISTRATION  
POLICY CHANGE INDEX**

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b><u>OTHER</u></b>
1	COUNTY ADMINISTRATION BASE
2	SAWS
3	IMPLEMENTATION OF ACA
4	CalWORKs APPLICATIONS
5	TRANSITION OF HFP TO MEDI-CAL
6	FY 2013-14 COST OF DOING BUSINESS
7	LOS ANGELES COUNTY HOSPITAL INTAKES
8	STATE-ONLY FORMER FOSTER CARE PROGRAM
9	FY 2014-2015 COST OF DOING BUSINESS
11	SAVE
12	REDUCTION TO COLA TO COUNTIES FOR FY 2014-15
13	PRIOR YEAR RECONCILIATIONS
14	ENHANCED FEDERAL FUNDING

## COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1704

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$1,302,683,000	\$0	\$1,302,683,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$1,302,683,000	\$0	\$1,302,683,000
STATE FUNDS	\$0	\$651,341,500	\$0	\$651,341,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$1,302,683,000	\$0	\$1,302,683,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$1,302,683,000	\$0	\$1,302,683,000
STATE FUNDS	\$0	\$651,341,500	\$0	\$651,341,500

### DESCRIPTION

**Purpose:**

This policy change reflects the base allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. The base estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

The base estimate consists of the costs identified for three sub-categories: (1) staff costs (2) staff development, and (3) support costs.

1. Staff Costs

This amount includes the estimated costs for staff in three staff categories: eligibility workers and supervisors, clerical support staff, and administrative staff. The staff costs for each of the three categories will be allocated to individual counties to fund all Medi-Cal eligibility determination activities.

**COUNTY ADMINISTRATION BASE**

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

**2. Support Costs**

Support costs are a combination of two types of expenditures: operating support costs and electronic data processing costs. These two types of expenditures are further divided into allocated costs and direct costs.

- a. Allocated costs are those that are shared across all programs and distributed to individual programs based on a ratio developed from the total expenditures for each program.
- b. Direct costs are specific to the Medi-Cal program only.

**3. Staff Development**

Staff development costs are the costs of training Medi-Cal eligibility workers. The amount in this item includes:

- a. Trainers' salaries and benefits.
- b. Operating costs related to training.
- c. Trainees' salaries and benefits.
- d. Travel, per diem, supplies and tuition.
- e. Purchase of contracted training services.

The base allocation for county administration of the Medi-Cal program for FY 2013-14 includes the FY 2012-13 eligible growth.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

Base Allocation	In Thousands		
	<u>TF</u>	<u>GF</u>	<u>FFP</u>
<b>FY 2013-14</b>	<b>\$1,302,683</b>	<b>\$651,341</b>	<b>\$651,342</b>
<b>FY 2014-15</b>	<b>\$1,302,683</b>	<b>\$651,341</b>	<b>\$651,342</b>

**Funding:**

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

## SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 2  
 IMPLEMENTATION DATE: 7/1987  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 214

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$175,602,000	\$0	\$155,135,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$175,602,000	\$0	\$155,135,000	\$0
STATE FUNDS	\$7,566,000	\$0	\$7,566,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$175,602,000	\$0	\$155,135,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$175,602,000	\$0	\$155,135,000	\$0
STATE FUNDS	\$7,566,000	\$0	\$7,566,000	\$0

## DESCRIPTION

**Purpose:**

This policy change estimates and reimburses the California Department of Social Services (CDSS) 100% Federal Financial Participation (FFP) for automated Eligibility Determination and Automated Benefit Computation. This policy change also estimates the funds for the Los Angeles Eligibility Automated Determination Evaluation and Reposting System (LEADER) that is paid by the Department.

**Authority:**

Welfare & Institutions Code 14154  
 Interagency Agreement #04-35639  
 Affordable Care Act (ACA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Statewide Automated Welfare Systems (SAWS) consists of three county consortium systems: LEADER, the Consortium-IV (C-IV), and the CalWORKs Information Network (CalWIN).

The SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

LEADER is the automated system for Los Angeles County and is currently in the maintenance and operation phase. The County began the process to replace the LEADER system and has entered the

## SAWS

### COUNTY ADMIN. POLICY CHANGE NUMBER: 2

development phase of the process with the contractor Accenture. OSI and the County have submitted the LEADER Replacement System (LRS) development contract to the federal oversight agencies for their review and approval. While the replacement system is being developed, the County received state and federal approval to extend the existing LEADER maintenance and operations contract for an additional two years, through April 2015. The Department plans to seek optional extensions to the contract.

The CalWIN consortium is fully implemented in all 18 counties and is currently in the maintenance and operation phase.

The C-IV system is fully implemented in 39 counties and is currently in the maintenance and operation phase.

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. The C-IV Migration will result in a new consortium to replace the LEADER and C-IV consortia.

The Department plans to upgrade and expand the current county call center infrastructure to interface with Covered California's Service Center and Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). Expansion of SAWS is required to meet the increase in call volume and the increase in services provided to beneficiaries.

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

CDSS updated estimated expenditures for FY 2013-14 and FY 2014-15. In addition, costs increased for LEADER Replacement and for the SAWS Customer Service Center.

#### **Methodology:**

1. The cash basis estimate was provided by CDSS.

(Dollars In Thousands)	<u>FY 2013-14</u>	<u>FY 2014-15</u>
LA County LEADER M&O*	\$15,132 (\$7,566 GF)	\$15,132 (\$7,566 GF)
LEADER Replacement	\$73,385	\$80,883
SAWS Customer Service Center	\$35,877	\$0
SPM	\$1,518	\$1,518
WCDS-CalWIN	\$19,984	\$27,566
Consortia IV	\$17,903	\$25,708
State Client Index	\$69	\$69
CalHEERS Development	\$11,132	\$3,757
CAIHEERS Interface M&O	\$419	\$419
Consortium-IV Migration	\$183	\$83
<b>Total</b>	<u><b>\$175,602</b></u>	<u><b>\$155,135</b></u>

#### **Funding:**

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

Title XIX FFP (4260-101-0890)

## IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER: 3  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1796

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$13,759,000	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$130,086,000	\$0	\$130,086,000
<b>TOTAL FUNDS</b>	<b>\$13,759,000</b>	<b>\$130,086,000</b>	<b>\$0</b>	<b>\$130,086,000</b>
STATE FUNDS	\$6,879,500	\$65,043,000	\$0	\$65,043,000
<b>% IN BASE</b>				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
<b>APPLIED TO BASE</b>				
PROCEDURAL - TOT.	\$13,759,000	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$130,086,000	\$0	\$130,086,000
<b>TOTAL FUNDS</b>	<b>\$13,759,000</b>	<b>\$130,086,000</b>	<b>\$0</b>	<b>\$130,086,000</b>
STATE FUNDS	\$6,879,500	\$65,043,000	\$0	\$65,043,000

### DESCRIPTION

**Purpose:**

This policy change estimates the county administrative costs for implementing required provisions of the Affordable Care Act (ACA).

**Authority:**

Not Applicable

**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 the uninsured. The Department anticipates that the mandatory requirements will encourage many eligible individuals to enroll in the Medi-Cal program.

Additionally, the ACA mandates the establishment of online health insurance exchanges. Covered California, California's online health insurance exchange provides competitive health care coverage for individuals and small employers. As required by ACA, Covered California determines an applicant's eligibility for subsidized coverage. The ACA also requires states to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs.

## IMPLEMENTATION OF ACA

### COUNTY ADMIN. POLICY CHANGE NUMBER: 3

Covered California offers applicants the option to file online, in person, by mail, by telephone with the exchange, or with the county welfare departments (CWD). To meet this requirement, the Department and Covered California formed a partnership to develop the CalHEERS system. CalHEERS allows for the one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.

This policy change estimates the administrative costs for processing new applications and redeterminations, training costs, statewide/county level planning and implementation, and also curriculum development for county staff.

#### Reason for Change from Prior Estimate:

There is no change.

#### Methodology:

1. Effective January 1, 2014, the ACA simplifies eligibility for several coverage groups (Children, Pregnant Women, and 1931b). Open enrollment for Covered California begins October 1, 2013.
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.
3. In FY 2013-14 and FY 2014-15, the Department estimates the cost of processing new applications will be \$78,715,000 TF (\$39,357,500 GF) and \$51,371,000 TF (\$25,685,500 GF) for redeterminations.
4. In FY 2013-14, the Department estimates the cost for developing the training curriculum and providing training to county eligibility workers will be \$8,059,000 TF (\$4,029,500 GF).
5. In FY 2013-14, the Department estimates the County/Statewide planning and implementation support will be \$5,700,000 TF (\$2,850,000 GF).
6. In FY 2013-14 the total estimated county administrative costs are:

(Dollars in Thousands)

#### FY 2013-14

	TF	GF
New Applications	\$78,715	\$39,358
Redeterminations	\$51,371	\$25,686
Training costs	\$8,059	\$4,030
County/Statewide Planning and Implementation support costs	\$5,700	\$2,850
<b>Total</b>	<b>\$143,845</b>	<b>\$71,923</b>

**IMPLEMENTATION OF ACA**  
**COUNTY ADMIN. POLICY CHANGE NUMBER: 3**

7. In FY 2014-15 the total estimated county administrative costs are:

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>
New Applications	\$78,715	\$39,358
Redeterminations	\$51,371	\$25,686
<b>Total</b>	<b>\$130,086</b>	<b>\$65,044</b>

**Funding:**

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

## CalWORKs APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4  
 IMPLEMENTATION DATE: 7/1998  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 217

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$64,896,000	\$0	\$67,503,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$64,896,000	\$0	\$67,503,000
STATE FUNDS	\$0	\$32,448,000	\$0	\$33,751,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$64,896,000	\$0	\$67,503,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$64,896,000	\$0	\$67,503,000
STATE FUNDS	\$0	\$32,448,000	\$0	\$33,751,500

### DESCRIPTION

**Purpose:**

This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Since 1998, the Department shares in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility to be shared between the three programs.

**Reason for Change from Prior Estimate:**

CDSS updated estimated expenditures for FY 2014-15. No change for FY 2013-14.

## CalWORKs APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

**Methodology:**

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2013-14	\$64,896,000	\$32,448,000	\$32,448,000
FY 2014-15	\$67,503,000	\$33,751,500	\$33,751,500

**Funding:**

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

## TRANSITION OF HFP TO MEDI-CAL

COUNTY ADMIN. POLICY CHANGE NUMBER: 5  
 IMPLEMENTATION DATE: 12/2012  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1598

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$54,363,000	\$0	\$43,054,000
TOTAL FUNDS	\$0	\$54,363,000	\$0	\$43,054,000
STATE FUNDS	\$0	\$19,027,050	\$0	\$15,068,900
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$54,363,000	\$0	\$43,054,000
TOTAL FUNDS	\$0	\$54,363,000	\$0	\$43,054,000
STATE FUNDS	\$0	\$19,027,050	\$0	\$15,068,900

### DESCRIPTION

**Purpose:**

This policy change budgets the county administration costs associated with transitioning of 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:**

Effective January 1, 2013, HFP subscribers began a transition into Medi-Cal through a phase-in methodology. HFP will send to the counties the current subscribers' applications and information. The counties will process the applications. Administrative savings will be reflected in the Managed Risk Medical Insurance Board budget.

**Reason for Change from Prior Estimate:**

In the May Appropriation, Phase 4 counties were scheduled to transition in September. Now due to delays, some Phase 4 counties transitioned in November. Additionally, the Department is rolling over funding in FY 2013-14 for counties who did not spend all of their FY 2012-13 allocations.

**TRANSITION OF HFP TO MEDI-CAL****COUNTY ADMIN. POLICY CHANGE NUMBER: 5****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. It is assumed the HFP caseload will experience 0.30% of annual growth in FY 2013-14 and FY 2014-15.
2. The Transition of HFP subscribers into the Medi-Cal program occurs in four separate phases. The first phase was split into four stages transitioning January 1, 2013, March 1, 2013, April 1, 2013, and May 1, 2013 for all HFP subscribers 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 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.
3. Estimated costs:

(In Thousands)	<b>TF</b>	<b>GF</b>
<b>FY 2013-14</b>		
Ongoing Costs	\$39,648	\$13,877
FY 2012-13 Rollover	\$14,715	\$5,150
<b>Total</b>	<b>\$54,363</b>	<b>\$19,027</b>
	<b>TF</b>	<b>GF</b>
<b>FY 2014-15</b>	<b>\$43,054</b>	<b>\$15,069</b>

**Funding:**

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

## FY 2013-14 COST OF DOING BUSINESS

COUNTY ADMIN. POLICY CHANGE NUMBER: 6  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1705

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$30,813,000	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$30,813,000	\$0	\$0
STATE FUNDS	\$0	\$15,406,500	\$0	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$30,813,000	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$30,813,000	\$0	\$0
STATE FUNDS	\$0	\$15,406,500	\$0	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The COLA is determined by the allowable county salaries at the California Necessities Index (CNI) or state employee salary increases, whichever is greater. The current State employee contracts do not allow for increase in FY 2013-14. Therefore, the Department of Finance (DOF) calculation of 3.49% for the CNI for FY 2013-14 will be used.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. Assume the CNI for FY 2013-14 is 3.49%.
2. The FY 2012-13 staff salary cost is \$882,891,000.

## **FY 2013-14 COST OF DOING BUSINESS**

**COUNTY ADMIN. POLICY CHANGE NUMBER: 6**

**FY 2013-14 Cost of Doing Business:**

\$882,891,000 x 3.49% = **\$30,813,000 TF (\$15,406,500 GF)**

**Funding:**

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

## LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 7  
 IMPLEMENTATION DATE: 7/1994  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 213

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$26,037,000	\$0	\$15,313,000
TOTAL FUNDS	\$0	\$26,037,000	\$0	\$15,313,000
STATE FUNDS	\$0	\$2,308,000	\$0	\$3,561,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$26,037,000	\$0	\$15,313,000
TOTAL FUNDS	\$0	\$26,037,000	\$0	\$15,313,000
STATE FUNDS	\$0	\$2,308,000	\$0	\$3,561,500

### DESCRIPTION

**Purpose:**

The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. The applications processed by the PFSWs are sent to the Los Angeles County Human Services Agency for final eligibility determination. Welfare & Institutions Code Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services eligibility workers for regular Medi-Cal intakes.

**Reason for Change from Prior Estimate:**

The change is due to additional data and completion of the reconciliation.

**Methodology:**

1. PFSWs processed an average of 1,452 intakes per month in calendar year 2012. The Department anticipates Los Angeles to process 1,452 or more intakes per month in calendar years 2014 and 2015. The Department is anticipating an increase in the number of intakes due to the Affordable Care Act; therefore, the Department plans to freeze the funding for FY 2013-14 at FY 2012-13

**LOS ANGELES COUNTY HOSPITAL INTAKES****COUNTY ADMIN. POLICY CHANGE NUMBER: 7**

levels. These intakes are reported separately to the Department and are not included in the base estimate. The average reimbursement rate is \$268 for both current year and budget year. Assume in FY 2013-2014 and FY 2014-2015, PFSWs will continue processing at 2,215 per month.

FY 2013-14:  $2,215 \times \$268 \times 12 = \$7,123,000$  (\$3,561,500 GF)

FY 2014-15:  $2,215 \times \$268 \times 12 = \$7,123,000$  (\$3,561,500 GF)

- In FY 2012-13, the Department completed the FY 2010-11 Los Angeles County Hospital Intakes reconciliation. The reconciliation resulted in a refund to Los Angeles of \$13,428,000. The Department plans to pay \$13,428,000 in FY 2013-14, which includes a federal pass-through amount of \$13,231,000.
- In FY 2013-14, the Department completed the FY 2011-2012 Los Angeles County Hospital Intakes reconciliation. The reconciliation resulted in a refund to Los Angeles of \$5,486,000, which includes a federal pass-through of \$8,190,000 due to the county. The net result is lower due to \$2,704,000 owed to the Department for processing a lower number of intakes. Assume the same amount of federal fund pass-through is needed in FY 2014-15 for the reconciliation of FY 2012-13.

(Dollars in Thousands)

	FY 2013-14			FY 2014-15		
	TF	GF	FFP	TF	GF	FFP
PFSW Base	\$7,123	\$3,561	\$3,562	\$7,123	\$3,561	\$3,562
FY 2010-11 Recon.	\$197	\$99	\$98	\$0	\$0	\$0
FY 2010-11 Pass.	\$13,231	\$0	\$13,231	\$0	\$0	\$0
FY 2011-12 Pass.	\$8,190	\$0	\$8,190	\$0	\$0	\$0
FY 2011-12 Recon.	(\$2,704)	(\$1,352)	(\$1,352)	\$0	\$0	\$0
FY 2012-13 Pass.	\$0	\$0	\$0	\$8,190	\$0	\$8,190
<b>Total</b>	<b>\$26,037</b>	<b>\$2,308</b>	<b>\$23,729</b>	<b>\$15,313</b>	<b>\$3,561</b>	<b>\$11,752</b>

**Funding:**

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

100% Title XIX (4260-101-0890)

## STATE-ONLY FORMER FOSTER CARE PROGRAM

COUNTY ADMIN. POLICY CHANGE NUMBER: 8  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1803

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$99,000	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$99,000	\$0	\$0	\$0
STATE FUNDS	\$99,000	\$0	\$0	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$99,000	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$99,000	\$0	\$0	\$0
STATE FUNDS	\$99,000	\$0	\$0	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates county administrative costs related to extending Medi-Cal benefits 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:**

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). 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:**

There is no change.

**STATE-ONLY FORMER FOSTER CARE PROGRAM**

COUNTY ADMIN. POLICY CHANGE NUMBER: 8

**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.
3. In FY 2013-14, the total estimated county administrative costs are:

(Dollars in Thousands)

**FY 2013-14 costs**TF  
\$99GF  
\$99FF  
\$0**Funding:**

100% GF (4260-101-0001)

## FY 2014-2015 COST OF DOING BUSINESS

COUNTY ADMIN. POLICY CHANGE NUMBER: 9  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1827

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$20,218,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$20,218,000
STATE FUNDS	\$0	\$0	\$0	\$10,109,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$20,218,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$20,218,000
STATE FUNDS	\$0	\$0	\$0	\$10,109,000

### DESCRIPTION

**Purpose:**

This policy change estimates the Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

CA-12 Reduction to COLA to Counties for FY 2014-2015

**Background:**

The COLA is determined by the allowable county salaries at the California Necessities Index (CNI) or state employee salary increases, whichever is greater. The current State employee contracts do not allow for increase in FY 2014-15. Therefore, the Department of Finance (DOF) calculation of 2.29% for the CNI for FY 2014-15 will be used.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

1. Assume the CNI for FY 2014-15 is 2.29%.
2. The FY 2013-14 staff salary cost is \$882,892,297.

## **FY 2014-2015 COST OF DOING BUSINESS**

**COUNTY ADMIN. POLICY CHANGE NUMBER: 9**

**FY 2014-15 Cost of Doing Business:**

**\$882,892,297 x 2.29% = \$20,218,000 TF (\$10,109,000 GF)**

**Funding:**

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

**SAVE**

COUNTY ADMIN. POLICY CHANGE NUMBER: 11  
 IMPLEMENTATION DATE: 10/1988  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 215

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$3,500,000	\$0	-\$3,500,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$3,500,000	\$0	-\$3,500,000	\$0

**DESCRIPTION****Purpose:**

The policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Immigration Reform and Control Act (IRCA) of 1986 required states to use the SAVE system to verify alien status for Medi-Cal applicants beginning in October 1988. The counties time study eligibility worker and supervisor time spent on SAVE verifications.

**Reason for Change from Prior Estimate:**

There is no change.

**SAVE**

COUNTY ADMIN. POLICY CHANGE NUMBER: 11

**Methodology:**

1. The Medi-Cal accrual costs for SAVE reported over the last five years by the counties were:

FY 2007-08*	\$7,350,704
FY 2008-09*	\$17,430,750
FY 2009-10*	\$6,881,956
FY 2010-11*	\$6,431,214
FY 2011-12**	\$6,413,123
FY 2012-13**	\$6,418,755

2. The Department conducted a SAVE review in May 2008 to determine if counties were consistently following SAVE program requirements. The Department found that eligibility workers were not consistently maintaining required copies of SAVE documents in the beneficiary case files. Counties were required to reconcile the beneficiary case files and make sure all documentation was included. This review caused a one-time increase in SAVE costs in FY 2008-09 on an accrual basis. On a cash basis, the impact occurred in FY 2010-11.

Based on claims through June 2012, Federal funds will be:

	<u>Total Fund</u>	<u>FFP Shift</u>
<b>FY 2013-14</b>	\$7,000,000	<b>\$3,500,000</b>
<b>FY 2014-15</b>	\$7,000,000	<b>\$3,500,000</b>

\* Actual

\*\* Preliminary

**Funding:**

100% GF (4260-101-0001)

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

## REDUCTION TO COLA TO COUNTIES FOR FY 2014-15

COUNTY ADMIN. POLICY CHANGE NUMBER: 12  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1825

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	-\$20,218,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	-\$20,218,000
STATE FUNDS	\$0	\$0	\$0	-\$10,109,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	-\$20,218,000
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	-\$20,218,000
STATE FUNDS	\$0	\$0	\$0	-\$10,109,000

### DESCRIPTION

**Purpose:**

This policy change estimates the savings for eliminating the Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

CA-9 FY 2014-15 Cost of Doing Business

**Background:**

The COLA is determined by the allowable county salaries at the California Necessities Index (CNI) or state employee salary increases, whichever is greater. The COLA for FY 2014-15 is projected to be \$20,218,000 TF (\$10,109,000 GF) based on the CNI increase which is 2.29%.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

1. Assume the CNI for FY 2014-15 is 2.29%.
2. The FY 2013-14 staff salary cost is \$882,892,000.

## REDUCTION TO COLA TO COUNTIES FOR FY 2014-15

COUNTY ADMIN. POLICY CHANGE NUMBER: 12

**FY 2014-15 Cost of Doing Business:**

\$882,892,297 x 2.29% = \$20,218,000 TF (\$10,109,000 GF)

The Reduction to COLA is **\$20,218,000 TF (\$10,109,000 GF)**.

**Funding:**

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

## PRIOR YEAR RECONCILIATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 13  
 IMPLEMENTATION DATE: 12/2011  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1191

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	-\$37,678,000	\$0	-\$35,881,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	-\$37,678,000	\$0	-\$35,881,000	\$0
STATE FUNDS	-\$18,839,000	\$0	-\$17,940,500	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	-\$37,678,000	\$0	-\$35,881,000	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	-\$37,678,000	\$0	-\$35,881,000	\$0
STATE FUNDS	-\$18,839,000	\$0	-\$17,940,500	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the reconciliation of county administration expenditures to the county administration allocation.

**Authority:**

Welfare & Institutions Code 14154

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Two years following the end of the fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quarterly administrative claim, which is used by the Department for the county administration reconciliation process.

**Reason for Change from Prior Estimate:**

The Department completed the final reconciliation for FY 2011-12 and an interim reconciliation for FY 2012-13. Claimed expenditures for FY 2012-13 were higher than expected.

**Methodology:**

- In FY 2012-13, the Department completed the final reconciliation for FY 2010-11 and interim reconciliation for FY 2011-12. The Department collected the third installment payment in the first quarter of FY 2013-14. The total amount is \$1,797,000.

**PRIOR YEAR RECONCILIATIONS**

COUNTY ADMIN. POLICY CHANGE NUMBER: 13

2. The Department completed the final reconciliation of FY 2011-12 and an interim reconciliation for FY 2012-13. The final reconciliation of FY 2011-12 includes all final amendments and adjustments to the quarterly administrative claim.
3. In FY 2014-15, the final reconciliation for FY 2012-13 will be completed.

(Dollars in Thousands)

**FY 2013-14**

	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2012-13 Interim Reconciliation	(\$35,881)	(\$17,940)	(\$17,941)
FY 2011-12 Final Reconciliation	(\$1,797)	(\$898)	(\$899)
<b>Total FY 2013-14</b>	<b>(\$37,678)</b>	<b>(\$18,838)</b>	<b>(\$18,840)</b>

**FY 2014-15**

FY 2012-13 Final Reconciliation	<b>(\$35,881)</b>	<b>(\$17,940)</b>	<b>(\$17,941)</b>
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**Funding:**

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

## ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 14  
 IMPLEMENTATION DATE: 1/2014  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1835

	FY 2013-14		FY 2014-15	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$124,201,000	\$0	-\$248,402,000	\$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	\$0	\$0	\$0	\$0
CASELOAD - TOT.	\$0	\$0	\$0	\$0
TOTAL FUNDS	\$0	\$0	\$0	\$0
STATE FUNDS	-\$124,201,000	\$0	-\$248,402,000	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

**Authority:**

Not applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Generally, payments to counties for making Medi-Cal eligibility determinations are budgeted at 50% federal funding. However, the Centers for Medicare and Medicaid Services (CMS) has published guidance that allows for federal funding at 75% for some of these functions. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.

In order to secure the enhanced funding, there are various conditions required of a MMIS. Also, there are minimum critical success factors for accepting the new applications, making modified adjusted gross income (MAGI) determinations and coordination with Covered California. The Department must submit an advanced planning document (APD) and secure CMS approval.

## ENHANCED FEDERAL FUNDING

### COUNTY ADMIN. POLICY CHANGE NUMBER: 14

The Department has been in discussions with CMS to clarify the requirements for enhanced funding. The APD is being developed in order to submit it to CMS for approval.

#### Reason for Change from Prior Estimate:

New policy change

#### Methodology:

1. Assume a January 1, 2014, effective date for approval of the Department's APD.
2. Assume that 70% of county administration costs are eligible for the enhanced funding because they are application, on-going case maintenance and redetermination costs.
3. 70% of county administration costs are an estimated \$993,608,000.
4. The savings are estimated to be:

(Dollars in thousands)

	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2013-14</b>			
Funding at 50% FFP	\$496,804	\$248,402	\$248,402
Funding at 75% FFP	<u>\$496,804</u>	<u>\$124,201</u>	<u>\$372,603</u>
<b>Difference</b>	<b>\$0</b>	<b>(\$124,201)</b>	<b>\$124,201</b>
<b>FY 2014-15</b>			
Funding at 50% FFP	\$993,608	\$496,804	\$496,804
Funding at 75% FFP	<u>\$993,608</u>	<u>\$248,402</u>	<u>\$745,206</u>
<b>Difference</b>	<b>\$0</b>	<b>(\$248,402)</b>	<b>\$248,402</b>

5. This funding adjustment is shown here as a one-time cost. The ongoing impact would be shown in the County Administration Base policy change.

#### Funding:

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

Title XIX 75/25 FFP (4260-101-0001/0890)

## OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14		FISCAL YEAR 2014-15	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>					
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$431,815,000	\$0	\$253,823,000	\$0
2	CCS CASE MANAGEMENT	\$175,885,000	\$68,086,800	\$179,902,000	\$69,636,300
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$137,795,000	\$0	\$155,785,000	\$0
4	BTR—LIHP - ADMINISTRATIVE COSTS	\$102,861,000	\$0	\$115,177,000	\$0
5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$47,779,000	\$0	\$13,321,000	\$0
6	EPSDT CASE MANAGEMENT	\$33,718,000	\$11,871,300	\$33,718,000	\$11,871,300
7	SMH MAA	\$28,193,000	\$0	\$25,966,000	\$0
8	CALHEERS DEVELOPMENT	\$27,709,000	\$7,859,500	\$19,705,000	\$6,327,400
9	ACA OUTREACH AND ENROLLMENT ASSISTORS	\$26,500,000	\$13,250,000	\$26,500,000	\$13,250,000
10	TRANSITION OF HFP TO MEDI-CAL	\$26,104,000	\$9,136,400	\$18,426,000	\$6,449,100
11	ARRA HITECH INCENTIVE PROGRAM	\$21,206,000	\$1,984,000	\$36,225,000	\$3,404,000
12	POSTAGE & PRINTING	\$19,245,000	\$9,713,500	\$17,832,000	\$9,019,500
13	ACA EXPANSION ADMIN COSTS	\$16,825,000	\$8,412,500	\$8,325,000	\$4,162,500
14	COUNTY UR & QA ADMIN	\$16,558,000	\$0	\$17,203,000	\$0
15	MIS/DSS CONTRACT	\$10,900,000	\$2,892,800	\$10,900,000	\$2,897,000
16	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000
17	CCI - DUAL ELIGIBLE DEMONSTRATION PROJECT	\$8,786,000	\$2,543,000	\$8,070,000	\$2,543,000
18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITI	\$7,837,000	\$1,560,300	\$3,644,000	\$539,600
19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	\$6,368,000	\$973,200	\$6,290,000	\$753,600
20	ADHC TRANSITION-ADMINISTRATION	\$6,172,000	\$3,086,000	\$0	\$0
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,631,000	\$1,889,000	\$5,913,000	\$1,983,800
22	MEDI-CAL RECOVERY CONTRACTS	\$5,290,000	\$1,322,500	\$5,709,000	\$1,427,300
23	COORDINATED CARE MANAGEMENT PILOT	\$4,716,000	\$2,358,000	\$118,000	\$59,000
24	RESTORATION OF SELECT ADULT DENTAL BENEFITS	\$905,000	\$286,000	\$19,906,000	\$6,275,000
25	PASRR	\$3,366,000	\$841,500	\$6,400,000	\$1,600,000

## OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14		FISCAL YEAR 2014-15	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>					
26	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$2,992,000	\$1,022,000	\$2,015,000	\$1,003,800
27	FAMILY PACT EVALUATION	\$2,861,000	\$1,430,500	\$2,861,000	\$1,430,500
28	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	\$2,835,000	\$0	\$2,660,000	\$0
29	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,420,000	\$1,210,000	\$2,662,000	\$1,331,000
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$2,016,000	\$504,000	\$2,487,000	\$621,800
31	SDMC SYSTEM M&O SUPPORT	\$1,500,000	\$750,000	\$1,959,000	\$979,500
32	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500
33	BUSINESS RULES EXTRACTION	\$1,100,000	\$550,000	\$1,900,000	\$950,000
34	MEDS INTERFACE WITH CALHEERS	\$1,008,000	\$852,800	\$477,000	\$410,900
35	MITA	\$1,000,000	\$100,000	\$481,000	\$48,100
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$950,000	\$950,000	\$950,000
37	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$856,000	\$428,000	\$856,000	\$428,000
38	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000
39	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$560,000	\$0	\$560,000	\$0
40	MEDS MODERNIZATION PROJECT CONTRACTORS	\$546,000	\$54,600	\$4,533,000	\$453,300
41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$539,000	\$269,500	\$567,000	\$283,500
42	VITAL RECORDS DATA	\$508,000	\$0	\$836,000	\$0
44	CCT OUTREACH - ADMINISTRATIVE COSTS	\$485,000	\$0	\$242,000	\$0
45	ETL DATA SOLUTION	\$469,000	\$77,900	\$0	\$0
46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$400,000	\$200,000	\$240,000	\$120,000
47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	\$350,000	\$87,500	\$0	\$0
48	DENTAL PAPD PROJECT MANAGER	\$240,000	\$120,000	\$239,000	\$119,500
49	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	\$214,000	\$107,000	\$0	\$0
50	ANNUAL EDP AUDIT CONTRACTOR	\$162,000	\$81,000	\$162,000	\$81,000
51	EPOCRATES	\$107,000	\$53,500	\$107,000	\$53,500

## OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14		FISCAL YEAR 2014-15	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>					
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$100,000	\$0
53	TAR POSTAGE	\$99,000	\$49,500	\$99,000	\$49,500
54	DMHC INTER-AGENCY AGREEMENT - ADMIN	\$79,000	\$0	\$95,000	\$0
55	KATIE A. V. DIANA BONTA SPECIAL MASTER	\$70,000	\$35,000	\$70,000	\$35,000
56	Q5i AUTOMATED DATA SYSTEM ACQUISITION	\$42,000	\$21,000	\$39,000	\$19,500
57	RECOVERY AUDIT CONTRACTOR COSTS	\$2,000	\$1,000	\$14,000	\$7,000
58	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$0	\$0	\$14,726,000	\$4,197,000
59	NEWBORN HEARING SCREENING PROGRAM	\$0	\$0	\$4,136,000	\$2,068,000
60	RATE STUDIES FOR MAIC AND AAC VENDOR	\$0	\$0	\$1,000,000	\$500,000
80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	\$250,000	\$125,000	\$250,000	\$125,000
	<b>CDHS SUBTOTAL</b>	<b>\$1,208,861,000</b>	<b>\$163,114,400</b>	<b>\$1,048,118,000</b>	<b>\$164,432,000</b>
<b>OTHER DEPARTMENTS</b>					
61	PERSONAL CARE SERVICES	\$262,937,000	\$0	\$249,240,000	\$0
62	HEALTH-RELATED ACTIVITIES - CDSS	\$219,207,000	\$0	\$232,467,000	\$0
63	CDDS ADMINISTRATIVE COSTS	\$40,187,000	\$0	\$31,196,000	\$0
64	MATERNAL AND CHILD HEALTH	\$29,169,000	\$0	\$29,702,000	\$0
65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE	\$25,143,000	\$0	\$25,143,000	\$0
66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$33,229,000	\$0	\$27,499,000	\$0
67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS	\$18,730,000	\$2,780,000	\$17,156,000	\$2,533,000
68	CLPP CASE MANAGEMENT SERVICES	\$7,400,000	\$0	\$5,200,000	\$0
69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	\$7,049,000	\$2,784,400	\$7,049,000	\$2,784,400
70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$3,072,000	\$0	\$3,563,000	\$0
71	CDPH I&E PROGRAM AND EVALUATION	\$1,375,000	\$0	\$1,237,000	\$0
72	CDDS DENTAL SERVICES	\$1,270,000	\$1,270,000	\$1,270,000	\$1,270,000
73	KIT FOR NEW PARENTS	\$1,017,000	\$0	\$1,017,000	\$0

## OTHER ADMINISTRATION POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14		FISCAL YEAR 2014-15	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER DEPARTMENTS</b>					
74	QUITLINE ADMINISTRATIVE SERVICES	\$1,000,000	\$0	\$2,000,000	\$0
75	VETERANS BENEFITS	\$956,000	\$0	\$956,000	\$0
76	CHHS AGENCY HIPAA FUNDING	\$651,000	\$0	\$651,000	\$0
77	MERIT SYSTEM SERVICES FOR COUNTIES	\$195,000	\$97,500	\$195,000	\$97,500
78	FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTREACH	\$53,000	\$0	\$0	\$0
79	PIA EYEWEAR COURIER SERVICE	\$324,000	\$162,000	\$360,000	\$180,000
<b>OTHER DEPARTMENTS SUBTOTAL</b>		<b>\$652,964,000</b>	<b>\$7,093,900</b>	<b>\$635,901,000</b>	<b>\$6,864,900</b>
<b>GRAND TOTAL</b>		<b>\$1,861,825,000</b>	<b>\$170,208,300</b>	<b>\$1,684,019,000</b>	<b>\$171,296,900</b>

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

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>								
1	1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$303,000,000	\$0	\$431,815,000	\$0	\$128,815,000	\$0
2	2	CCS CASE MANAGEMENT	\$174,950,000	\$67,638,500	\$175,885,000	\$68,086,800	\$935,000	\$448,300
3	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$141,726,000	\$0	\$137,795,000	\$0	-\$3,931,000	\$0
4	4	BTR—LIHP - ADMINISTRATIVE COSTS	\$742,976,000	\$0	\$102,861,000	\$0	-\$640,115,000	\$0
5	6	EPSDT CASE MANAGEMENT	\$33,718,000	\$11,871,250	\$33,718,000	\$11,871,250	\$0	\$0
7	8	CALHEERS DEVELOPMENT	\$27,134,000	\$8,063,800	\$27,709,000	\$7,859,450	\$575,000	-\$204,350
8	12	POSTAGE & PRINTING	\$25,427,000	\$12,653,700	\$19,245,000	\$9,713,500	-\$6,182,000	-\$2,940,200
9	7	SMH MAA	\$24,509,000	\$0	\$28,193,000	\$0	\$3,684,000	\$0
10	14	COUNTY UR & QA ADMIN	\$16,798,000	\$0	\$16,558,000	\$0	-\$240,000	\$0
11	5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$26,641,000	\$0	\$47,779,000	\$0	\$21,138,000	\$0
12	23	COORDINATED CARE MANAGEMENT PILOT	\$4,716,000	\$2,358,000	\$4,716,000	\$2,358,000	\$0	\$0
13	10	TRANSITION OF HFP TO MEDI-CAL	\$24,134,000	\$8,446,900	\$26,104,000	\$9,136,400	\$1,970,000	\$689,500
14	15	MIS/DSS CONTRACT	\$10,900,000	\$2,892,750	\$10,900,000	\$2,892,750	\$0	\$0
15	16	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
16	21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,435,000	\$1,828,000	\$5,631,000	\$1,889,000	\$196,000	\$61,000
17	22	MEDI-CAL RECOVERY CONTRACTS	\$5,009,000	\$1,252,250	\$5,290,000	\$1,322,500	\$281,000	\$70,250
18	19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	\$6,704,000	\$803,000	\$6,368,000	\$973,150	-\$336,000	\$170,150
19	17	CCI - DUAL ELIGIBLE DEMONSTRATION PROJECT	\$5,172,000	\$2,542,500	\$8,786,000	\$2,543,000	\$3,614,000	\$500
20	18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRA	\$3,315,000	\$396,900	\$7,837,000	\$1,560,300	\$4,522,000	\$1,163,400
21	28	PREVENTION OF CHRONIC DISEASE GRANT PROJEC	\$2,500,000	\$0	\$2,835,000	\$0	\$335,000	\$0
22	27	FAMILY PACT EVALUATION	\$2,861,000	\$1,430,500	\$2,861,000	\$1,430,500	\$0	\$0
23	11	ARRA HITECH INCENTIVE PROGRAM	\$2,626,000	\$154,000	\$21,206,000	\$1,984,000	\$18,580,000	\$1,830,000
24	29	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,530,000	\$1,265,000	\$2,420,000	\$1,210,000	-\$110,000	-\$55,000
25	20	ADHC TRANSITION-ADMINISTRATION	\$656,000	\$328,000	\$6,172,000	\$3,086,000	\$5,516,000	\$2,758,000
26	34	MEDS INTERFACE WITH CALHEERS	\$1,008,000	\$852,800	\$1,008,000	\$852,800	\$0	\$0
27	32	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500	\$0	\$0
28	30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$2,000,000	\$500,000	\$2,016,000	\$504,000	\$16,000	\$4,000
29	36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$950,000	\$950,000	\$950,000	\$0	\$0
30	37	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$856,000	\$428,000	\$856,000	\$428,000	\$0	\$0
32	39	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$560,000	\$0	\$560,000	\$0	\$0	\$0

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

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>								
33	41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$572,000	\$286,000	\$539,000	\$269,500	-\$33,000	-\$16,500
34	48	DENTAL PAPD PROJECT MANAGER	\$288,000	\$144,000	\$240,000	\$120,000	-\$48,000	-\$24,000
35	46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$400,000	\$200,000	\$400,000	\$200,000	\$0	\$0
36	44	CCT OUTREACH - ADMINISTRATIVE COSTS	\$727,000	\$0	\$485,000	\$0	-\$242,000	\$0
37	38	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
38	47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	\$350,000	\$87,500	\$350,000	\$87,500	\$0	\$0
39	40	MEDS MODERNIZATION PROJECT CONTRACTORS	\$546,000	\$54,600	\$546,000	\$54,600	\$0	\$0
41	49	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	\$102,000	\$51,000	\$214,000	\$107,000	\$112,000	\$56,000
42	--	HEALTH CARE OPTIONS CONSULTANT COSTS	\$222,000	\$111,000	\$0	\$0	-\$222,000	-\$111,000
43	51	EPOCRATES	\$107,000	\$53,500	\$107,000	\$53,500	\$0	\$0
44	55	KATIE A. V. DIANA BONTA SPECIAL MASTER	\$100,000	\$50,000	\$70,000	\$35,000	-\$30,000	-\$15,000
45	52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$100,000	\$0	\$0	\$0
46	53	TAR POSTAGE	\$106,000	\$53,000	\$99,000	\$49,500	-\$7,000	-\$3,500
47	56	Q5i AUTOMATED DATA SYSTEM ACQUISITION	\$87,000	\$43,500	\$42,000	\$21,000	-\$45,000	-\$22,500
48	25	PASRR	\$3,616,000	\$904,000	\$3,366,000	\$841,500	-\$250,000	-\$62,500
49	31	SDMC SYSTEM M&O SUPPORT	\$1,834,000	\$917,000	\$1,500,000	\$750,000	-\$334,000	-\$167,000
50	50	ANNUAL EDP AUDIT CONTRACTOR	\$400,000	\$200,000	\$162,000	\$81,000	-\$238,000	-\$119,000
51	57	RECOVERY AUDIT CONTRACTOR COSTS	\$9,000	\$4,500	\$2,000	\$1,000	-\$7,000	-\$3,500
75	45	ETL DATA SOLUTION	\$469,000	\$77,900	\$469,000	\$77,900	\$0	\$0
76	42	VITAL RECORDS DATA	\$926,000	\$0	\$508,000	\$0	-\$418,000	\$0
78	13	ACA EXPANSION ADMIN COSTS	\$19,085,000	\$9,542,500	\$16,825,000	\$8,412,500	-\$2,260,000	-\$1,130,000
79	24	RESTORATION OF SELECT ADULT DENTAL BENEFITS	\$4,255,000	\$1,350,000	\$905,000	\$286,000	-\$3,350,000	-\$1,064,000
--	9	ACA OUTREACH AND ENROLLMENT ASSISTORS	\$0	\$0	\$26,500,000	\$13,250,000	\$26,500,000	\$13,250,000
--	26	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$0	\$0	\$2,992,000	\$1,022,000	\$2,992,000	\$1,022,000
--	33	BUSINESS RULES EXTRACTION	\$0	\$0	\$1,100,000	\$550,000	\$1,100,000	\$550,000
--	35	MITA	\$0	\$0	\$1,000,000	\$100,000	\$1,000,000	\$100,000
--	54	DMHC INTER-AGENCY AGREEMENT - ADMIN	\$0	\$0	\$79,000	\$0	\$79,000	\$0
--	80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	\$0	\$0	\$250,000	\$125,000	\$250,000	\$125,000
<b>CDHS SUBTOTAL</b>			<b>\$1,645,049,000</b>	<b>\$146,754,350</b>	<b>\$1,208,861,000</b>	<b>\$163,114,400</b>	<b>-\$436,188,000</b>	<b>\$16,360,050</b>

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

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER DEPARTMENTS</b>								
52	61	PERSONAL CARE SERVICES	\$262,751,000	\$0	\$262,937,000	\$0	\$186,000	\$0
53	62	HEALTH-RELATED ACTIVITIES - CDSS	\$218,951,000	\$0	\$219,207,000	\$0	\$256,000	\$0
54	63	CDDS ADMINISTRATIVE COSTS	\$33,875,000	\$0	\$40,187,000	\$0	\$6,312,000	\$0
55	64	MATERNAL AND CHILD HEALTH	\$34,190,000	\$0	\$29,169,000	\$0	-\$5,021,000	\$0
56	65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER	\$25,143,000	\$0	\$25,143,000	\$0	\$0	\$0
57	68	CLPP CASE MANAGEMENT SERVICES	\$5,200,000	\$0	\$7,400,000	\$0	\$2,200,000	\$0
58	66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$24,111,000	\$0	\$33,229,000	\$0	\$9,118,000	\$0
59	70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$3,146,000	\$0	\$3,072,000	\$0	-\$74,000	\$0
60	75	VETERANS BENEFITS	\$956,000	\$0	\$956,000	\$0	\$0	\$0
61	71	CDPH I&E PROGRAM AND EVALUATION	\$1,557,000	\$0	\$1,375,000	\$0	-\$182,000	\$0
64	67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	\$19,005,000	\$2,433,000	\$18,730,000	\$2,780,000	-\$275,000	\$347,000
65	72	CDDS DENTAL SERVICES	\$1,270,000	\$1,270,000	\$1,270,000	\$1,270,000	\$0	\$0
66	73	KIT FOR NEW PARENTS	\$1,017,000	\$0	\$1,017,000	\$0	\$0	\$0
67	74	QUITLINE ADMINISTRATIVE SERVICES	\$2,000,000	\$0	\$1,000,000	\$0	-\$1,000,000	\$0
68	76	CHHS AGENCY HIPAA FUNDING	\$651,000	\$0	\$651,000	\$0	\$0	\$0
69	--	FAMILY PACT EVALUATION	\$63,000	\$0	\$0	\$0	-\$63,000	\$0
70	78	FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTRE	\$27,000	\$0	\$53,000	\$0	\$26,000	\$0
72	77	MERIT SYSTEM SERVICES FOR COUNTIES	\$184,000	\$92,000	\$195,000	\$97,500	\$11,000	\$5,500
73	69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	\$7,049,000	\$2,784,400	\$7,049,000	\$2,784,400	\$0	\$0
74	79	PIA EYEWEAR COURIER SERVICE	\$324,000	\$162,000	\$324,000	\$162,000	\$0	\$0
<b>OTHER DEPARTMENTS SUBTOTAL</b>			<b>\$641,470,000</b>	<b>\$6,741,400</b>	<b>\$652,964,000</b>	<b>\$7,093,900</b>	<b>\$11,494,000</b>	<b>\$352,500</b>
<b>OTHER ADMINISTRATION SUBTOTAL</b>			<b>\$2,286,519,000</b>	<b>\$153,495,750</b>	<b>\$1,861,825,000</b>	<b>\$170,208,300</b>	<b>-\$424,694,000</b>	<b>\$16,712,550</b>
<b>GRAND TOTAL COUNTY AND OTHER ADMIN.</b>			<b>\$3,980,303,000</b>	<b>\$909,141,350</b>	<b>\$3,622,485,000</b>	<b>\$823,786,850</b>	<b>-\$357,818,000</b>	<b>-\$85,354,500</b>

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

NOV. PC#	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>							
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	\$431,815,000	\$0	\$253,823,000	\$0	-\$177,992,000	\$0
2	CCS CASE MANAGEMENT	\$175,885,000	\$68,086,800	\$179,902,000	\$69,636,250	\$4,017,000	\$1,549,450
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	\$137,795,000	\$0	\$155,785,000	\$0	\$17,990,000	\$0
4	BTR—LIHP - ADMINISTRATIVE COSTS	\$102,861,000	\$0	\$115,177,000	\$0	\$12,316,000	\$0
5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	\$47,779,000	\$0	\$13,321,000	\$0	-\$34,458,000	\$0
6	EPSDT CASE MANAGEMENT	\$33,718,000	\$11,871,250	\$33,718,000	\$11,871,250	\$0	\$0
7	SMH MAA	\$28,193,000	\$0	\$25,966,000	\$0	-\$2,227,000	\$0
8	CALHEERS DEVELOPMENT	\$27,709,000	\$7,859,450	\$19,705,000	\$6,327,400	-\$8,004,000	-\$1,532,050
9	ACA OUTREACH AND ENROLLMENT ASSISTORS	\$26,500,000	\$13,250,000	\$26,500,000	\$13,250,000	\$0	\$0
10	TRANSITION OF HFP TO MEDI-CAL	\$26,104,000	\$9,136,400	\$18,426,000	\$6,449,100	-\$7,678,000	-\$2,687,300
11	ARRA HITECH INCENTIVE PROGRAM	\$21,206,000	\$1,984,000	\$36,225,000	\$3,404,000	\$15,019,000	\$1,420,000
12	POSTAGE & PRINTING	\$19,245,000	\$9,713,500	\$17,832,000	\$9,019,500	-\$1,413,000	-\$694,000
13	ACA EXPANSION ADMIN COSTS	\$16,825,000	\$8,412,500	\$8,325,000	\$4,162,500	-\$8,500,000	-\$4,250,000
14	COUNTY UR & QA ADMIN	\$16,558,000	\$0	\$17,203,000	\$0	\$645,000	\$0
15	MIS/DSS CONTRACT	\$10,900,000	\$2,892,750	\$10,900,000	\$2,897,000	\$0	\$4,250
16	LITIGATION RELATED SERVICES	\$9,980,000	\$4,990,000	\$9,980,000	\$4,990,000	\$0	\$0
17	CCI - DUAL ELIGIBLE DEMONSTRATION PROJECT	\$8,786,000	\$2,543,000	\$8,070,000	\$2,543,000	-\$716,000	\$0
18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRAN	\$7,837,000	\$1,560,300	\$3,644,000	\$539,550	-\$4,193,000	-\$1,020,750
19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	\$6,368,000	\$973,150	\$6,290,000	\$753,600	-\$78,000	-\$219,550
20	ADHC TRANSITION-ADMINISTRATION	\$6,172,000	\$3,086,000	\$0	\$0	-\$6,172,000	-\$3,086,000
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	\$5,631,000	\$1,889,000	\$5,913,000	\$1,983,750	\$282,000	\$94,750
22	MEDI-CAL RECOVERY CONTRACTS	\$5,290,000	\$1,322,500	\$5,709,000	\$1,427,250	\$419,000	\$104,750
23	COORDINATED CARE MANAGEMENT PILOT	\$4,716,000	\$2,358,000	\$118,000	\$59,000	-\$4,598,000	-\$2,299,000
24	RESTORATION OF SELECT ADULT DENTAL BENEFITS	\$905,000	\$286,000	\$19,906,000	\$6,275,000	\$19,001,000	\$5,989,000
25	PASRR	\$3,366,000	\$841,500	\$6,400,000	\$1,600,000	\$3,034,000	\$758,500
26	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	\$2,992,000	\$1,022,000	\$2,015,000	\$1,003,750	-\$977,000	-\$18,250
27	FAMILY PACT EVALUATION	\$2,861,000	\$1,430,500	\$2,861,000	\$1,430,500	\$0	\$0

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

NOV. PC#	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>							
28	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	\$2,835,000	\$0	\$2,660,000	\$0	-\$175,000	\$0
29	SSA COSTS FOR HEALTH COVERAGE INFO.	\$2,420,000	\$1,210,000	\$2,662,000	\$1,331,000	\$242,000	\$121,000
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	\$2,016,000	\$504,000	\$2,487,000	\$621,750	\$471,000	\$117,750
31	SDMC SYSTEM M&O SUPPORT	\$1,500,000	\$750,000	\$1,959,000	\$979,500	\$459,000	\$229,500
32	FAMILY PACT PROGRAM ADMIN.	\$1,207,000	\$603,500	\$1,207,000	\$603,500	\$0	\$0
33	BUSINESS RULES EXTRACTION	\$1,100,000	\$550,000	\$1,900,000	\$950,000	\$800,000	\$400,000
34	MEDS INTERFACE WITH CALHEERS	\$1,008,000	\$852,800	\$477,000	\$410,900	-\$531,000	-\$441,900
35	MITA	\$1,000,000	\$100,000	\$481,000	\$48,100	-\$519,000	-\$51,900
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	\$950,000	\$950,000	\$950,000	\$950,000	\$0	\$0
37	MMA - DSH ANNUAL INDEPENDENT AUDIT	\$856,000	\$428,000	\$856,000	\$428,000	\$0	\$0
38	ENCRYPTION OF PHI DATA	\$750,000	\$375,000	\$750,000	\$375,000	\$0	\$0
39	MEDI-CAL INPATIENT SERVICES FOR INMATES	\$560,000	\$0	\$560,000	\$0	\$0	\$0
40	MEDS MODERNIZATION PROJECT CONTRACTORS	\$546,000	\$54,600	\$4,533,000	\$453,300	\$3,987,000	\$398,700
41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	\$539,000	\$269,500	\$567,000	\$283,500	\$28,000	\$14,000
42	VITAL RECORDS DATA	\$508,000	\$0	\$836,000	\$0	\$328,000	\$0
44	CCT OUTREACH - ADMINISTRATIVE COSTS	\$485,000	\$0	\$242,000	\$0	-\$243,000	\$0
45	ETL DATA SOLUTION	\$469,000	\$77,900	\$0	\$0	-\$469,000	-\$77,900
46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	\$400,000	\$200,000	\$240,000	\$120,000	-\$160,000	-\$80,000
47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	\$350,000	\$87,500	\$0	\$0	-\$350,000	-\$87,500
48	DENTAL PAPD PROJECT MANAGER	\$240,000	\$120,000	\$239,000	\$119,500	-\$1,000	-\$500
49	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	\$214,000	\$107,000	\$0	\$0	-\$214,000	-\$107,000
50	ANNUAL EDP AUDIT CONTRACTOR	\$162,000	\$81,000	\$162,000	\$81,000	\$0	\$0
51	EPOCRATES	\$107,000	\$53,500	\$107,000	\$53,500	\$0	\$0
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	\$100,000	\$0	\$100,000	\$0	\$0	\$0
53	TAR POSTAGE	\$99,000	\$49,500	\$99,000	\$49,500	\$0	\$0
54	DMHC INTER-AGENCY AGREEMENT - ADMIN	\$79,000	\$0	\$95,000	\$0	\$16,000	\$0
55	KATIE A. V. DIANA BONTA SPECIAL MASTER	\$70,000	\$35,000	\$70,000	\$35,000	\$0	\$0

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

NOV. PC#	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>CDHS</b>							
56	Q5i AUTOMATED DATA SYSTEM ACQUISTION	\$42,000	\$21,000	\$39,000	\$19,500	-\$3,000	-\$1,500
57	RECOVERY AUDIT CONTRACTOR COSTS	\$2,000	\$1,000	\$14,000	\$7,000	\$12,000	\$6,000
58	DRUG MEDI-CAL COUNTY ADMINISTRATION	\$0	\$0	\$14,726,000	\$4,197,000	\$14,726,000	\$4,197,000
59	NEWBORN HEARING SCREENING PROGRAM	\$0	\$0	\$4,136,000	\$2,068,000	\$4,136,000	\$2,068,000
60	RATE STUDIES FOR MAIC AND AAC VENDOR	\$0	\$0	\$1,000,000	\$500,000	\$1,000,000	\$500,000
80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	\$250,000	\$125,000	\$250,000	\$125,000	\$0	\$0
	<b>CDHS SUBTOTAL</b>	<b>\$1,208,861,000</b>	<b>\$163,114,400</b>	<b>\$1,048,118,000</b>	<b>\$164,431,950</b>	<b>-\$160,743,000</b>	<b>\$1,317,550</b>
<b>OTHER DEPARTMENTS</b>							
61	PERSONAL CARE SERVICES	\$262,937,000	\$0	\$249,240,000	\$0	-\$13,697,000	\$0
62	HEALTH-RELATED ACTIVITIES - CDSS	\$219,207,000	\$0	\$232,467,000	\$0	\$13,260,000	\$0
63	CDDS ADMINISTRATIVE COSTS	\$40,187,000	\$0	\$31,196,000	\$0	-\$8,991,000	\$0
64	MATERNAL AND CHILD HEALTH	\$29,169,000	\$0	\$29,702,000	\$0	\$533,000	\$0
65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER C	\$25,143,000	\$0	\$25,143,000	\$0	\$0	\$0
66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	\$33,229,000	\$0	\$27,499,000	\$0	-\$5,730,000	\$0
67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	\$18,730,000	\$2,780,000	\$17,156,000	\$2,533,000	-\$1,574,000	-\$247,000
68	CLPP CASE MANAGEMENT SERVICES	\$7,400,000	\$0	\$5,200,000	\$0	-\$2,200,000	\$0
69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	\$7,049,000	\$2,784,400	\$7,049,000	\$2,784,400	\$0	\$0
70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	\$3,072,000	\$0	\$3,563,000	\$0	\$491,000	\$0
71	CDPH I&E PROGRAM AND EVALUATION	\$1,375,000	\$0	\$1,237,000	\$0	-\$138,000	\$0
72	CDDS DENTAL SERVICES	\$1,270,000	\$1,270,000	\$1,270,000	\$1,270,000	\$0	\$0
73	KIT FOR NEW PARENTS	\$1,017,000	\$0	\$1,017,000	\$0	\$0	\$0
74	QUITLINE ADMINISTRATIVE SERVICES	\$1,000,000	\$0	\$2,000,000	\$0	\$1,000,000	\$0
75	VETERANS BENEFITS	\$956,000	\$0	\$956,000	\$0	\$0	\$0
76	CHHS AGENCY HIPAA FUNDING	\$651,000	\$0	\$651,000	\$0	\$0	\$0
77	MERIT SYSTEM SERVICES FOR COUNTIES	\$195,000	\$97,500	\$195,000	\$97,500	\$0	\$0
78	FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTREA	\$53,000	\$0	\$0	\$0	-\$53,000	\$0

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

NOV. PC#	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2013-14		NOV. 2013 EST. FOR 2014-15		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	<b>OTHER DEPARTMENTS</b>						
79	PIA EYEWEAR COURIER SERVICE	\$324,000	\$162,000	\$360,000	\$180,000	\$36,000	\$18,000
	<b>OTHER DEPARTMENTS SUBTOTAL</b>	<b>\$652,964,000</b>	<b>\$7,093,900</b>	<b>\$635,901,000</b>	<b>\$6,864,900</b>	<b>-\$17,063,000</b>	<b>-\$229,000</b>
	<b>OTHER ADMINISTRATION SUBTOTAL</b>	<b>\$1,861,825,000</b>	<b>\$170,208,300</b>	<b>\$1,684,019,000</b>	<b>\$171,296,850</b>	<b>-\$177,806,000</b>	<b>\$1,088,550</b>
	<b>GRAND TOTAL COUNTY AND OTHER ADMIN.</b>	<b>\$3,622,485,000</b>	<b>\$823,786,850</b>	<b>\$3,361,912,000</b>	<b>\$677,786,750</b>	<b>-\$260,573,000</b>	<b>-\$146,000,100</b>

**MEDI-CAL OTHER ADMINISTRATION  
POLICY CHANGE INDEX**

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b><u>CDHS</u></b>
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES
2	CCS CASE MANAGEMENT
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN
4	BTR—LIHP - ADMINISTRATIVE COSTS
5	INTERIM AND FINAL COST SETTLEMENTS-SMHS
6	EPSDT CASE MANAGEMENT
7	SMH MAA
8	CALHEERS DEVELOPMENT
9	ACA OUTREACH AND ENROLLMENT ASSISTORS
10	TRANSITION OF HFP TO MEDI-CAL
11	ARRA HITECH INCENTIVE PROGRAM
12	POSTAGE & PRINTING
13	ACA EXPANSION ADMIN COSTS
14	COUNTY UR & QA ADMIN
15	MIS/DSS CONTRACT
16	LITIGATION RELATED SERVICES
17	CCI - DUAL ELIGIBLE DEMONSTRATION PROJECT
18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION
19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT
20	ADHC TRANSITION-ADMINISTRATION
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
22	MEDI-CAL RECOVERY CONTRACTS
23	COORDINATED CARE MANAGEMENT PILOT
24	RESTORATION OF SELECT ADULT DENTAL BENEFITS
25	PASRR
26	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY
27	FAMILY PACT EVALUATION
28	PREVENTION OF CHRONIC DISEASE GRANT PROJECT
29	SSA COSTS FOR HEALTH COVERAGE INFO.
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM
31	SDMC SYSTEM M&O SUPPORT
32	FAMILY PACT PROGRAM ADMIN.
33	BUSINESS RULES EXTRACTION
34	MEDS INTERFACE WITH CALHEERS
35	MITA
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

## MEDI-CAL OTHER ADMINISTRATION POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>CDHS</u></b>	
37	MMA - DSH ANNUAL INDEPENDENT AUDIT
38	ENCRYPTION OF PHI DATA
39	MEDI-CAL INPATIENT SERVICES FOR INMATES
40	MEDS MODERNIZATION PROJECT CONTRACTORS
41	POSTAGE AND PRINTING - THIRD PARTY LIAB.
42	VITAL RECORDS DATA
44	CCT OUTREACH - ADMINISTRATIVE COSTS
45	ETL DATA SOLUTION
46	MEDICARE BUY-IN QUALITY REVIEW PROJECT
47	MIS/DSS CONTRACT REPROCUREMENT SERVICES
48	DENTAL PAPD PROJECT MANAGER
49	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION
50	ANNUAL EDP AUDIT CONTRACTOR
51	EPOCRATES
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT
53	TAR POSTAGE
54	DMHC INTER-AGENCY AGREEMENT - ADMIN
55	KATIE A. V. DIANA BONTA SPECIAL MASTER
56	Q5i AUTOMATED DATA SYSTEM ACQUISITION
57	RECOVERY AUDIT CONTRACTOR COSTS
58	DRUG MEDI-CAL COUNTY ADMINISTRATION
59	NEWBORN HEARING SCREENING PROGRAM
60	RATE STUDIES FOR MAIC AND AAC VENDOR
80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS
<b><u>OTHER DEPARTMENTS</u></b>	
61	PERSONAL CARE SERVICES
62	HEALTH-RELATED ACTIVITIES - CDSS
63	CDDS ADMINISTRATIVE COSTS
64	MATERNAL AND CHILD HEALTH
65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE
66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
68	CLPP CASE MANAGEMENT SERVICES
69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY
70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS

**MEDI-CAL OTHER ADMINISTRATION  
POLICY CHANGE INDEX**

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b><u>OTHER DEPARTMENTS</u></b>
71	CDPH I&E PROGRAM AND EVALUATION
72	CDDS DENTAL SERVICES
73	KIT FOR NEW PARENTS
74	QUITLINE ADMINISTRATIVE SERVICES
75	VETERANS BENEFITS
76	CHHS AGENCY HIPAA FUNDING
77	MERIT SYSTEM SERVICES FOR COUNTIES
78	FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTREACH
79	PIA EYEWEAR COURIER SERVICE

## MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1  
 IMPLEMENTATION DATE: 7/1992  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 235

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$431,815,000	\$253,823,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$431,815,000	\$253,823,000

### DESCRIPTION

**Purpose:**

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs), local education agencies (LEAs), and Native American Indian tribes for Medicaid administrative activities.

**Authority:**

AB 2377 (Chapter 147, Statutes of 1994)  
 AB 2780 (Chapter 310, Statutes of 1998)  
 SB 308 (Chapter 253, Statutes of 2003)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

AB 2780 allowed LEAs (including school districts and county offices of education), the option of claiming MAA through either their local educational consortium (one of the State's eleven administrative districts) or through the LGAs.

SB 308 redefined LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows tribes to participate in MAA and Targeted Case Management programs. Reimbursements for non-emergency and non-medical transportation expenditures are also available for Tribal entities.

**Reason for Change from Prior Estimate:**

The change is due to the inclusion of previously deferred school-based MAA claims.

**Methodology:**

1. Assume an annual growth rate of 5%.

**MEDI-CAL ADMINISTRATIVE ACTIVITIES**

OTHER ADMIN. POLICY CHANGE NUMBER: 1

2. Total MAA reimbursements FY 2013-14 and FY 2014-15 on a cash basis are:

(Dollars In Thousands)	<u>TF</u>	<u>FF</u>
<b>FY 2013-14</b>	<b>431,815</b>	<b>431,815</b>
<b>FY 2014-15</b>	<b>253,823</b>	<b>253,823</b>

**Funding:**

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

## CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2  
 IMPLEMENTATION DATE: 7/1999  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 230

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$175,885,000	\$179,902,000
STATE FUNDS	\$68,086,800	\$69,636,250
FEDERAL FUNDS	\$107,798,200	\$110,265,750

### DESCRIPTION

**Purpose:**

This policy change estimates the California Children's Services (CCS) case management cost.

**Authority:**

Health & Safety Code, sections 123800-123995

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CCS county staff performs case management for clients who reside in counties with populations greater than 200,000 (independent counties). Case management includes performing all phases of program eligibility determination, evaluating the medical need for specific services, and determining appropriate providers. The state shares case management activities administered by CCS state regional office employees in Sacramento, San Francisco and Los Angeles for counties with populations less than 200,000 (dependent counties). The Children's Medical Services (CMS) Net automated system is utilized by the CCS Medi-Cal program to assure case management activities.

Effective January 1, 2013, the Healthy Family Program (HFP) ceased to enroll new subscribers and began transitioning HFP subscribers into Medi-Cal. HFP subscribers are scheduled to be phased-in beginning May 2013.

A portion of CCS case management transitions into the Health Plan of San Mateo (HPSM) beginning April 2013.

**Reason for Change from Prior Year:**

There is no material change.

**Methodology:**

1. The county administrative estimate for the budget year is updated every May based on additional data collected.
2. For FY 2013-14, the CCS case management costs are based on budgeted county expenditures of \$146,642,000 and the Pediatric Palliative Care (PPC) Nurse Liaisons cost of \$750,000 in the May 2013 Estimate.

$$\$146,642,000 + \$750,000 = \$147,392,000$$

**CCS CASE MANAGEMENT****OTHER ADMIN. POLICY CHANGE NUMBER: 2**

3. For FY 2014-15, caseload is expected to increase 1.74% from FY 2013-14 to FY 2014-15 based on the November 2013 Estimate. PPC Nurse Liaisons cost is estimated to be \$751,000 in FY 2014-15.

$$\$146,642,000 \times (1 + 1.74\%) = \$149,194,000 + 751,000 = \$149,945,000$$

4. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be \$2,709,000 in FY 2013-14 and \$2,698,000 in FY 2014-15.
5. The HFP transitioning into Medi-Cal consists of the following costs

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
County Administration:	\$27,965,000	\$29,225,000

6. County data processing costs associated with CMS Net for CCS HFP are estimated to be \$458,000 in FY 2013-14 and \$470,000 in FY 2014-15.
7. HPSM begins operation in April 2013 and receives monthly payments beginning May 2013. Payments to HPSM will be applied against CCS Case Management. All June payments will be made in July. The FY 2013-14 payment includes two months deferred payments from FY 2012-13 and the June 2014 payment will be deferred into FY 2014-15. The FY 2014-15 payment includes a net 12 months of cost.

FY 2013-14:	(\$2,639,000)
FY 2014-15:	(\$2,436,000)

8. AB 1745 requires the Department to conduct a waiver pilot project to determine whether PPC should be provided as a benefit under the Medi-Cal program. These expenditures have been rolled into the CCS case management costs.

<b>FY 2013-14</b>				<b>Reimburse-</b>
CCS Medi-Cal	<u>TF</u>	<u>GF</u>	<u>FF</u>	<u>ment*</u>
CCS Case Management	\$146,642,000	\$57,916,000	\$88,726,000	
Pediatric Palliative Care	\$750,000	\$187,000	\$563,000	
CMS Net	<u>\$2,709,000</u>	<u>\$1,354,000</u>	<u>\$1,355,000</u>	
	\$150,101,000	\$59,458,000	\$90,643,000	\$0
 Healthy Families Transition				
CCS Case Management	\$27,965,000	\$4,894,000	\$18,177,000	\$4,894,000
CMS Net	<u>\$458,000</u>	<u>\$160,000</u>	<u>\$298,000</u>	
	\$28,423,000	\$5,054,000	\$18,475,000	\$4,894,000
 Health Plan of San Mateo	<u>(\$2,639,000)</u>	<u>(\$1,319,000)</u>	<u>(\$1,320,000)</u>	
 <b>Total</b>	<b>\$175,885,000</b>	<b>\$63,193,000</b>	<b>\$107,798,000</b>	<b>\$4,894,000</b>

**CCS CASE MANAGEMENT**

OTHER ADMIN. POLICY CHANGE NUMBER: 2

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>Reimburse- ment*</b>
CCS Medi-Cal				
CCS Case Management	\$149,194,000	\$58,924,000	\$90,270,000	
Pediatric Pallative Care	\$751,000	\$188,000	\$563,000	
CMS Net	\$2,698,000	\$1,349,000	\$1,349,000	
	\$152,643,000	\$60,461,000	\$92,182,000	\$0
Healthy Families Transition				
CCS Case Management	\$29,225,000	\$5,114,000	\$18,996,000	\$4,894,000
CMS Net	\$470,000	\$164,000	\$306,000	
	\$29,695,000	\$5,279,000	\$19,302,000	\$4,894,000
Health Plan of San Mateo	(\$2,436,000)	(\$1,218,000)	(\$1,218,000)	\$0
<b>Total**</b>	<b>\$179,902,000</b>	<b>\$64,522,000</b>	<b>\$110,266,000</b>	<b>\$4,894,000</b>

\*\*Amounts differ due to rounding.

**Funding:**

(Dollars in Thousands)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>County</b>
50% GF / 50% Title XIX (4260-101-0001/0890)	\$85,093	\$42,546	\$42,547	
25% GF/ 75% Title XIX (4260-101-0001/0890)	\$62,369	\$15,592	\$46,777	
35% GF/ 65% Title XXI FFP (4260-113-0001/0890)	\$23,529	\$5,054	\$18,475	
100% Reimbursement GF (4260-610-0995)*	\$4,894			\$4,894
Total	\$175,885	\$63,192	\$107,799	\$4,894
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>County</b>
50% GF / 50% Title XIX (4260-101-0001/0890)	\$86,764	\$43,382	\$43,382	
25% GF/ 75% Title XIX (4260-101-0001/0890)	\$63,442	\$15,860	\$47,582	
35% GF/ 65% Title XXI FFP (4260-113-0001/0890)	\$24,581	\$5,279	\$19,302	
100% Reimbursement GF (4260-610-0995)*	\$4,894			\$4,894
Total**	\$179,681	\$64,521	\$110,266	\$4,894

\*\*Amounts differ due to rounding.

## COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 3  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1721

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$137,795,000	\$155,785,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$137,795,000	\$155,785,000

### DESCRIPTION

**Purpose:**

This policy change estimates the county administrative costs for the Specialty Mental Health Medi-Cal Waiver, Medicaid Children's Health Insurance Program, and Healthy Families Program administered by county mental health departments.

**Authority:**

Welfare & Institutions Code 14711(c)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Counties may obtain federal reimbursement for certain costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.

**Reason for Change from Prior Estimate:**

Administrative costs for SMHS for FY 2013-14 decreased in Medi-Cal based on updated expenditure data.

**Methodology:**

- Mental Health administration costs are based on historical trends. Below are the costs on an accrual basis for Medi-Cal (MC), Healthy Families Program (HFP), and Medicaid Children's Health Insurance Program (M-CHIP). Due to the transition of HFP to Medi-Cal, the HFP costs will entirely shift to M-CHIP in FY 2014-15.

(Dollars In Thousands)

Fiscal Year	MC	HFP	M-CHIP	Total
FY 2011-12	\$228,641	\$1,728	\$844	\$231,213
FY 2012-13	\$255,988	\$1,935	\$844	\$258,767
FY 2013-14	\$287,592	\$34	\$2,261	\$289,887
FY 2014-15	\$323,313	\$0	\$2,131	\$325,444

**COUNTY SPECIALTY MENTAL HEALTH ADMIN**

OTHER ADMIN. POLICY CHANGE NUMBER: 3

(Dollars In Thousands)

<u>Fiscal Year</u>	<u>Total</u>	<u>FFP</u>	<u>County</u>
FY 2011-12	\$231,213	\$115,992	\$115,221
FY 2012-13	\$258,767	\$129,800	\$128,967
FY 2013-14	\$289,887	\$145,288	\$144,599
FY 2014-15	\$325,444	\$163,042	\$162,402

2. Based on historical claims received, assume 60% of each fiscal year claims will be paid in the year the services occur. Assume 39% is paid in the following year and an additional 1% in the third year.

(Dollars In Thousands)

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2013-14</u>	<u>FY 2014-15</u>
MC	\$255,988	\$99,835	\$2,560
HFP	\$1,935	\$755	\$19
M-CHIP	\$844	\$329	\$8
FY 2012-13	\$258,767	\$100,919	\$2,587
MC	\$287,592	\$172,555	\$112,161
HFP	\$34	\$20	\$13
M-CHIP	\$2,261	\$1,357	\$882
FY 2013-14	\$289,887	\$173,932	\$113,056
MC	\$323,313	\$0	\$193,988
M-CHIP	\$2,131	\$0	\$1,279
FY 2014-15	\$325,444	\$0	\$195,266

3. Mental Health administration costs are shared between federal funds (FFP) and county funds. Healthy Families (HF) claims are eligible for federal reimbursement of 65%. Medi-Cal (MC) claims are eligible for 50% federal reimbursement.

(Dollars In Thousands)

<u>Claims</u>	<u>FY 2013-14</u>			<u>FY 2014-15</u>		
	<u>TF</u>	<u>FFP</u>	<u>County</u>	<u>TF</u>	<u>FFP</u>	<u>County</u>
MC	\$272,391	\$136,195	\$136,195	\$308,709	\$154,354	\$154,354
HFP*	\$775	\$504	\$271	\$33	\$21	\$11
M-CHIP*	\$1,686	\$1,096	\$590	\$2,169	\$1,410	\$759
<b>Total</b>	<b>\$274,851</b>	<b>\$137,795</b>	<b>\$137,057</b>	<b>\$310,910</b>	<b>\$155,785</b>	<b>\$155,125</b>

**Funding:**

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

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

## BTR—LIHP - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 4  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1589

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$102,861,000	\$115,177,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$102,861,000	\$115,177,000

### DESCRIPTION

**Purpose:**

This policy change estimates federal funds for the administrative costs associated with 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

**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 Health Care Coverage Initiative (HCCI). The MCE will cover eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI will cover those 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 (MH/UCD) 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 Centers for Medicare and Medicaid Services (CMS) will provide uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department has used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the section 1115(a) BTR Demonstration. The Department submitted a cost claiming protocol to CMS for approval of the administrative cost claiming for the BTR-LIHP.

**Reason for Change from Prior Estimate:**

Payment estimates have been revised due to updated county expenditures and pending CMS approval of the claiming protocol and time study.

**Methodology:**

1. Administrative payments will be based on a CMS approved administrative cost claiming protocol and

**BTR—LIHP - ADMINISTRATIVE COSTS****OTHER ADMIN. POLICY CHANGE NUMBER: 4**

time study.

2. Assume the Department will receive CMS' approval of the administrative cost claiming protocol and time study implementation plan in FY 2013-14.
3. Assume the time study process will be implemented in FY 2013-14.
4. The remaining administrative costs for FY 2011-12 (Demonstration Year 7, Quarter 1 only) will be claimed in FY 2013-14.
5. Invoices for administrative payments in FY 2011-12, FY 2012-13, and FY 2013-14 will be processed in FY 2013-14 and FY 2014-15.
6. Estimates for start-up costs are based on historical data and will be processed in FY 2013-14 and FY 2014-15.
7. Estimated administrative costs are expected to be as follows:

(Dollars in Thousands)	<b>LIHP- HCCI</b>	<b>LIHP- MCE</b>	<b>Total FFP</b>
<b>FY 2013-14</b>			
2011-12	\$2,416	\$34,414	\$36,830
2012-13	\$1,486	\$35,678	\$37,164
2013-14	\$1,154	\$27,713	\$28,867
<b>Total</b>	<b>\$5,056</b>	<b>\$97,805</b>	<b>\$102,861</b>
<b>FY 2014-15</b>			
2011-12	\$957	\$22,969	\$23,926
2012-13	\$2,495	\$59,889	\$62,384
2013-14	\$1,154	\$27,713	\$28,867
<b>Total</b>	<b>\$4,606</b>	<b>\$110,571</b>	<b>\$115,177</b>

**Funding:**

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

## INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 5  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1757

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$47,779,000	\$13,321,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$47,779,000	\$13,321,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal funds for the interim and final cost settlements on specialty mental health services (SMHS) administrative expenditures.

**Authority:**

Welfare & Institution Code 14705(c)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department reconciles interim settlements to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. 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 cost report the county 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 reimburse the federal funds.

**Reason for Change from Prior Estimate:**

Processing the claims for the cost settlement payments for FY 2008-09 were delayed and not paid in FY 2012-13. These payments will be paid in FY 2013-14.

**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.

**INTERIM AND FINAL COST SETTLEMENTS-SMHS**

OTHER ADMIN. POLICY CHANGE NUMBER: 5

3. Cost settlements for services, administration, UR/QA, and MH MAA are each determined separately.

(Dollars In Thousands)

	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net FFP</u>
<b>Interim Settlements (FY 2008-09)</b>			
SMH Admin	\$26,316	(\$14,481)	\$11,835
UR/QA	\$13,341	(\$1,103)	\$12,238
MH MAA	\$1,787	(\$1,728)	\$59
<b>Interim Settlements (FY 2009-10)</b>			
SMH Admin	\$24,686	(\$17,985)	\$6,701
M-CHIP*	\$1,347	\$0	\$1,347
UR/QA	\$15,452	(\$3,744)	\$11,708
MH MAA	\$11,252	(\$13,433)	(\$2,181)
Healthy Families*	\$1,568	\$0	\$1,568
<b>Interim Settlements (FY 2010-11)</b>			
SMH Admin	\$22,970	(\$21,736)	\$1,234
M-CHIP*	\$489	\$0	\$489
UR/QA	\$12,774	(\$1,241)	\$11,533
MH MAA	\$1,419	(\$2,689)	(\$1,270)
Healthy Families*	\$1,335	\$0	\$1,335
<b>Final Settlements (Multi-Years)</b>			
SMH Admin	\$1,540	(\$7,841)	(\$6,301)
M-CHIP*	\$0	\$0	\$0
UR/QA	\$795	(\$4,689)	(\$3,894)
MH MAA	\$5,568	(\$4,218)	\$1,350
Healthy Families*	\$59	(\$32)	\$27
<b>Total FY 2013-14</b>	<b>\$142,699</b>	<b>(\$94,920)</b>	<b>\$47,779</b>

(Dollars in Thousands)

	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net FFP</u>
<b>Interim Settlements (FY 2011-12)</b>			
SMH Admin	\$22,970	(\$21,736)	\$1,234
M-CHIP*	\$489	\$0	\$489
UR/QA	\$12,774	(\$1,241)	\$11,533
MHMAA	\$1,419	(\$2,689)	(\$1,270)
Healthy Families	\$1,335	\$0	\$1,335
<b>Total FY 2014-15</b>	<b>\$38,987</b>	<b>(\$25,666)</b>	<b>\$13,321</b>

## INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 5

**Funding:**

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

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

## EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 6  
 IMPLEMENTATION DATE: 7/1996  
 ANALYST: Yumie Park  
 FISCAL REFERENCE NUMBER: 229

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$33,718,000	\$33,718,000
STATE FUNDS	\$11,871,250	\$11,871,250
FEDERAL FUNDS	\$21,846,750	\$21,846,750

### DESCRIPTION

**Purpose:**

This policy change estimates Medi-Cal's Early and Periodic Screening Diagnosis and Treatment (EPSDT) Case Management allocation.

**Authority:**

Health & Safety Code 124075(a)  
 Welfare & Institutions Code 10507

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.

The EPSDT Case Management budget is allocated to individual counties and controlled on an accrual basis.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

- The set allocation amount is \$33,718,000 (\$11,871,250 GF) annually based on a formula calculated by the Child Health and Disability Prevention program.

	TF	GF	FFP
<b>Allocation</b>	<b>\$33,718,000</b>	<b>\$11,871,000</b>	<b>\$21,847,000</b>

**Funding:**

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

## SMH MAA

**OTHER ADMIN. POLICY CHANGE NUMBER:** 7  
**IMPLEMENTATION DATE:** 7/2012  
**ANALYST:** Julie Chan  
**FISCAL REFERENCE NUMBER:** 1722

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$28,193,000	\$25,966,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$28,193,000	\$25,966,000

### DESCRIPTION

**Purpose:**

This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of specialty mental health plans (MHPs) for Medicaid administrative activities.

**Authority:**

Welfare & Institutions Code 14132.47  
 AB 2377 (Chapter 147, Statutes of 1994)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

AB 2377 authorized the State to implement the Medi-Cal Administrative Claiming Process. The Specialty Mental Health Waiver program submits claims on behalf of MHPs to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the specialty mental health waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of specialty mental health services.

**Reason for Change from Prior Estimate:**

Fiscal Year 2012-13 has been increased by \$12,512,000 to account for one county whose claims were filed later than normal.

**Methodology:**

1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year (FY).
2. Based on claims from FY 2005-06 through FY 2011-12, the average annual increase in mental health (MH) Medi-Cal administrative activities (MAA) claims was 5.78%.
3. Assume claims will continue to increase by 5.78% each year for FY 2012-13, FY 2013-14, and FY 2014-15.

**SMH MAA**

OTHER ADMIN. POLICY CHANGE NUMBER: 7

4. In FY 2011-12, the Department received \$36,844,000 in MH MAA claims on an accrual basis.

(Dollars in Thousands)

<b>Fiscal Years</b>	<b>Expenditures</b>	<b>Growth</b>	<b>Increase</b>	<b>Revised Expenditures</b>
FY 2011-12	\$36,844	5.78%	\$2,130	\$38,973
FY 2012-13	\$38,973	5.78%	\$2,253	\$41,226
FY 2013-14	\$41,226	5.78%	\$2,383	\$43,609
FY 2014-15	\$43,609	5.78%	\$2,521	\$46,129

5. Based on historical claims received, assume 49.63% of fiscal year claims will be paid in the year the services occur. The remaining 50.37% is paid in the following year. Fiscal Year 2012-13 has been increased by \$12,512,000 to account for one county whose claims were filed later than normal. This pattern is not expected to continue in FYs 2013-14 and 2014-15.

(Dollars in Thousands)

<b>Fiscal Years</b>	<b>Accrual</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
FY 2012-13	\$51,485	\$25,933	\$0
FY 2013-14	\$41,226	\$20,460	\$20,765
FY 2014-15	\$43,609	\$0	\$21,966
Total	\$136,320	\$46,393	\$42,731

6. MH MAA total expenditures are shared between FFP and county funds. Skilled professional medical personnel are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

(Dollars in Thousands)

<b>Fiscal Year</b>	<b>TF</b>	<b>FY 2013-14</b>		<b>TF</b>	<b>FY 2014-15</b>	
		<b>FFP</b>	<b>County</b>		<b>FFP</b>	<b>County</b>
MAA expenditures	\$46,393	<b>\$28,193</b>	\$18,200	\$42,731	<b>\$25,966</b>	\$16,765

**Funding:**

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

## CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 8  
 IMPLEMENTATION DATE: 6/2012  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1679

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$27,709,000	\$19,705,000
STATE FUNDS	\$7,859,450	\$6,327,400
FEDERAL FUNDS	\$19,849,550	\$13,377,600

### DESCRIPTION

**Purpose:**

This policy change estimates the cost for developing, implementing, ongoing maintenance, and operations of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).

**Authority:**

Affordable Care Act (ACA) of 2010  
 Interagency Agreement  
 Contract

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The ACA mandates the establishment of health insurance exchanges, in California, known as the Health Benefit Exchange (HBEX) to provide competitive health care coverage for individuals and small employers. As required by ACA, States will use the HBEX to determine an applicant's eligibility for subsidized coverage. In creating this "one-stop-shop" experience, States are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person, by mail, by telephone with the HBEX, or with the Medicaid and Children's Health Insurance Program agency. To meet this requirement, the Department, the Healthy Families Program, and the HBEX have formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that will allow the required one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.

ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required HBEXs. Medi-Cal's associated cost for the development and implementation of CalHEERS is 18%; 17% is 10/90 FFP and 1% is 35/65 FFP.

**Reason for Change from Prior Estimate:**

Costs have been updated due to changes in the scope of the project.

**Methodology:**

1. Contractors began development and implementation (D&I) work in July 2012. Assume contractors will begin maintenance and operations (M&O) in January 2014.
2. Assume a one-time cost of \$313,148,911 for design, development, and implementation of CalHEERS beginning in FY 2012-13. Assume ongoing M&O costs totaling \$469,985,718 beginning in FY 2013-14.

**CALHEERS DEVELOPMENT****OTHER ADMIN. POLICY CHANGE NUMBER: 8**

3. CalHEERS' costs are shared between HBEX (82%) and Medi-Cal (18%). HBEX will reimburse the Department for their share.
4. In FY 2012-13, costs incurred are for CalHEERS' development and implementation. In FY 2013-14, costs incurred are for CalHEERS' development and implementation and maintenance and operations.
5. The design, development, and implementation period is eligible for:
  - 17% at 90% federal reimbursement.
  - 1% at 65% federal reimbursement.

The maintenance and operation period is eligible for:

- 17% at 75% federal reimbursement.
- 1% at 65% federal reimbursement.

**FY 2013-14 Title XIX**

Personnel	<u>Systems</u>	<u>Personnel</u>	<u>TF</u>	<u>Reimbursement</u>
CalHEERS		\$862,000	\$862,000	
Department Contractors		\$764,000	\$4,484,000	\$3,720,000
MRMIB		\$31,000	\$31,000	
CDSS		\$85,000	\$85,000	
OSI		\$239,000	\$239,000	
Systems Integration Services				
D&I	\$11,241,000		\$11,241,000	
O&M	\$6,291,000		\$6,291,000	
Interface Development				
D&I	\$380,500		\$380,500	
O&M	\$237,000		\$237,000	
IV & V Services				
D&I	\$74,500		\$74,500	
O&M	\$22,000		\$22,000	
Project Mgmt & Tech Support				
D&I	\$1,172,500		\$1,172,500	
O&M	\$158,000		\$158,000	
OTech Services				
D&I	\$608,500		\$608,500	
O&M	\$0		\$0	
CalHEERS Consultants				
D&I	\$106,000		\$106,000	
O&M	\$0		\$0	
<b>Total</b>	<b>\$20,291,000</b>	<b>\$1,981,000</b>	<b>\$25,992,000</b>	<b>\$3,720,000</b>

**CALHEERS DEVELOPMENT**

OTHER ADMIN. POLICY CHANGE NUMBER: 8

**FY 2013-14 Title XXI**

	<u>Systems</u>	<u>Personnel</u>	<u>TF</u>	<u>Reimbursement</u>
Personnel				
CalHEERS		\$50,500	\$50,500	
Department Contractors		\$44,000	\$44,000	
MRMIB		\$2,000	\$165,000	\$163,000
CDSS		\$5,000	\$5,000	
OSI		\$14,500	\$14,500	
Systems Integration Services				
D&I	\$661,000		\$661,000	
O&M	\$370,000		\$370,000	
Interface Development				
D&I	\$23,000		\$75,000	\$52,000
O&M	\$14,000		\$207,000	\$193,000
IV & V Services				
D&I	\$4,000		\$4,000	
O&M	\$1,000		\$1,000	
Project Mgmt & Tech Support				
D&I	\$68,000		\$68,000	
O&M	\$9,000		\$9,000	
OTech Services				
D&I	\$36,000		\$36,000	
O&M	\$0		\$0	
CalHEERS Consultants				
D&I	\$7,000		\$7,000	
O&M	\$0		\$0	
<b>Total</b>	<b>\$1,193,000</b>	<b>\$116,000</b>	<b>\$1,717,000</b>	<b>\$408,000</b>

**FY 2014-15 Title XIX**

	<u>Systems</u>	<u>Personnel</u>	<u>TF</u>	<u>Reimbursement</u>
Personnel				
CalHEERS		\$911,000	\$911,000	
Department Contractors		\$451,000	\$2,649,000	\$2,198,000
MRMIB		\$22,000	\$22,000	
CDSS		\$53,000	\$53,000	
OSI		\$242,000	\$242,000	
Systems Integration Services				
D&I	\$2,514,000		\$2,514,000	
O&M	\$10,411,000		\$10,411,000	
Interface Development				
D&I	\$28,500		\$28,500	
O&M	\$401,000		\$401,000	
IV & V Services				
D&I	\$51,500		\$51,500	
O&M	\$47,000		\$47,000	
Project Mgmt & Tech Support				

**CALHEERS DEVELOPMENT**

OTHER ADMIN. POLICY CHANGE NUMBER: 8

D&I	\$475,000		\$475,000	
O&M	\$341,000		\$341,000	
OTech Services				
D&I	\$82,000		\$82,000	
O&M	\$0		\$0	
CalHEERS Consultants				
D&I	\$7,000		\$7,000	
O&M	\$0		\$0	
<b>Total</b>	<b>\$14,358,000</b>	<b>\$1,679,000</b>	<b>\$18,235,000</b>	<b>\$2,198,000</b>
<b>FY 2014-15 Title XXI</b>				
Personnel	<u>Systems</u>	<u>Personnel</u>	<u>TF</u>	<u>Reimbursement</u>
CalHEERS		\$53,500	\$53,500	
Department Contractors		\$27,500	\$27,500	
MRMIB		\$1,000	\$125,000	\$124,000
CDSS		\$3,000	\$3,000	
OSI		\$14,000	\$14,000	
Systems Integration Services				
D&I	\$148,500		\$148,500	
O&M	\$613,000		\$613,000	
Interface Development				
D&I	\$2,000		\$2,000	
O&M	\$23,000		\$427,000	\$404,000
IV & V Services				
D&I	\$3,000		\$3,000	
O&M	\$3,000		\$3,000	
Project Mgmt & Tech Support				
D&I	\$28,500		\$28,500	
O&M	\$20,000		\$20,000	
OTech Services				
D&I	\$2,000		\$2,000	
O&M	\$0		\$0	
CalHEERS Consultants				
D&I	\$0		\$0	
O&M	\$0		\$0	
<b>Total</b>	<b>\$843,000</b>	<b>\$99,000</b>	<b>\$1,470,000</b>	<b>\$528,000</b>
(In thousands, rounded)	<u>TF</u>	<u>GF</u>	<u>FFP</u>	<u>Reimbursement</u>
<b>Total FY 2013-14:</b>	<b>\$27,709,000</b>	<b>\$3,731,450</b>	<b>\$19,849,550</b>	<b>\$4,128,000</b>
<b>Total FY 2014-15:</b>	<b>\$19,705,000</b>	<b>\$3,601,400</b>	<b>\$13,377,600</b>	<b>\$2,726,000</b>

**Funding:**

90% Title XIX / 10% GF (4260-101-0001/0890)

75% Title XIX / 25% GF (4260-101-0001/0890)

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

## ACA OUTREACH AND ENROLLMENT ASSISTORS

OTHER ADMIN. POLICY CHANGE NUMBER: 9  
 IMPLEMENTATION DATE: 1/2014  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1820

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$26,500,000	\$26,500,000
STATE FUNDS	\$13,250,000	\$13,250,000
FEDERAL FUNDS	\$13,250,000	\$13,250,000

### DESCRIPTION

**Purpose:**

This policy change estimates the costs for outreach and enrollment activities related to targeted Medi-Cal populations who are eligible as result of the Affordable Care Act (ACA).

**Authority:**

SB 101 (Chapter 23, Statutes of 2013)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Effective January 1, 2014, Medicaid will be expanded to include individuals between the ages of 19 up to 65 (primarily childless adults) with incomes up to 138% of the federal poverty level based on modified adjusted gross income. 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 the uninsured. These mandatory requirements will encourage many individuals who are currently eligible but not enrolled to enroll in Medi-Cal.

The Department partnered with Covered California to certify application assisters and provide outreach, enrollment, and marketing activities related to the ACA. This policy change estimates the costs for the outreach and enrollment of targeted Medi-Cal populations. Also included in this policy change are costs to compensate Medi-Cal in-person assisters. There will be special emphasis on targeting of the following populations:

- 1) Persons with mental health disorder needs;
- 2) Persons with substance use disorder needs;
- 3) Persons who are homeless;
- 4) Young men of color;
- 5) Persons who are in county jail, in state prison, on state parole, on county probation, or under post release community supervision;
- 6) Families of mixed-immigration status; and,
- 7) Persons with limited English proficiency.

The Department has established a special Healthcare Outreach and Medi-Cal Enrollment Account within a Special Deposit Fund to collect and allocate public or private grants to fund these activities.

## ACA OUTREACH AND ENROLLMENT ASSISTORS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

- 1) The Department estimates \$53,000,000 will be spent on these activities in FY 2013-14 and FY 2014-15. The funds will be spent as follows:

<b>FY 2013-14</b>	<b>TF</b>	<b>Special Fund</b>	<b>FF</b>
Application Assistors	\$14,000,000	\$7,000,000	\$7,000,000
Outreach and Enrollment	\$12,500,000	\$6,250,000	\$6,250,000
<b>Total</b>	<b>\$26,500,000</b>	<b>\$13,250,000</b>	<b>\$13,250,000</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>Special Fund</b>	<b>FF</b>
Application Assistors	\$14,000,000	\$7,000,000	\$7,000,000
Outreach and Enrollment	\$12,500,000	\$6,250,000	\$6,250,000
<b>Total</b>	<b>\$26,500,000</b>	<b>\$13,250,000</b>	<b>\$13,250,000</b>

**Funding:**

50% Title XIX FF / 50% Healthcare Outreach Fund (4260-108-0890/0942)

## TRANSITION OF HFP TO MEDI-CAL

OTHER ADMIN. POLICY CHANGE NUMBER: 10  
 IMPLEMENTATION DATE: 1/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1650

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$26,104,000	\$18,426,000
STATE FUNDS	\$9,136,400	\$6,449,100
FEDERAL FUNDS	\$16,967,600	\$11,976,900

### DESCRIPTION

**Purpose:**

This policy change estimates the contract cost for the single point of entry vendor assisting 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:**

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 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. This policy change estimates the single point of entry vendor costs related to customer services representatives, collections of monthly premiums, processing of initial and annual renewal applications, and mailing costs. All administrative savings related to the transition of HFP to Medi-Cal are reflected in the Managed Risk Medical Insurance Board (MRMIB) budget.

**Reason for Change from Prior Estimate:**

Actual certified eligible data (January through August 2013) was incorporated into the updated caseload projections. In FY 2013-14, the estimated member months increased from the May Appropriation.

**Methodology:**

1. Estimated costs:

(In Thousands)	TF	GF	FFP
<b>FY 2013-14</b>	<b>\$26,104</b>	\$9,136	\$16,968
<b>FY 2014-15</b>	<b>\$18,426</b>	\$6,449	\$11,977

**Funding:**

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

## ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 11  
 IMPLEMENTATION DATE: 7/2010  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1370

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$21,206,000	\$36,225,000
STATE FUNDS	\$1,984,000	\$3,404,000
FEDERAL FUNDS	\$19,222,000	\$32,821,000

### DESCRIPTION

**Purpose:**

This policy change estimates the administrative costs associated with the advancement of the Health Information Technology for Economic and Clinical Health (HITECH) Incentive Act under the American Recovery and Reinvestment Act (ARRA) of 2009.

**Authority:**

ARRA of 2009  
 SB 945 (Chapter 433, Statutes of 2011)  
 AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14046.7

**Interdependent Policy Changes:**

FI Estimate  
 PC-170 ARRA HITECH Provider Payments

**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 adopt, implement, or upgrade (AIU) and meaningfully use (MU) certified Electronic Health Records (EHR) technology in accordance with the HITECH Act requirements. The Centers for Medicare and Medicaid Services approved the implementation of the provider incentive program which began October 3, 2011. The payments to the providers under HITECH are budgeted in the ARRA HITECH – Provider Payments policy change.

In 2011, SB 945 authorized the Department to establish and administer the ARRA HITECH Incentive Program only to the extent that federal financial participation (FFP) was available and there would be no General Fund (GF) impact. In 2012, AB 1467 provided that no more than \$200,000 from the GF may be used annually for state administrative costs associated with the program.

The Department is required by CMS to assess the current usage of and barriers to EHR adoption by providers and continue maintenance of the Incentive Program; multiple contractors are required in order to complete the assessments. Also, the Department, in collaboration with a wide variety of stakeholder organizations, developed a Medi-Cal EHR Incentive Program Project Book that identifies a series of projects to help facilitate the ongoing development and evaluation of the program.

The Medi-Cal Fiscal Intermediary (FI), Xerox State Healthcare, LLC completed the development of an enrollment and eligibility portal for Medi-Cal professionals and hospitals. SB 945 limitations did not apply to the Xerox projects as the funding for these projects were approved as part of the FI budget prior to the passage of SB 945. The costs of the Xerox projects, which are eligible for FFP, are

## ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 11

budgeted in the FI Estimate as an optional contractual service. These costs include maintenance and operation and the development of additional functionalities.

The Department and the California Department of Public Health (CDPH) have partnered on a project to upgrade the California Immunization Registry (CAIR). The CAIR 2.0 project will transform the existing CAIR infrastructure and software to fully support MU data exchange among electronic health records, leveraging enhanced federal dollars.

In addition to CAIR 2.0, the Department will administer the following projects:

- The Department and CDPH will partner on the California Reportable Disease Information Exchange (CalREDIE) project to implement a computer application system for web-based disease reporting and surveillance. The CalREDIE project will improve the efficiency of surveillance activities and the early detection of public health events through the collection of more complete and timely surveillance information on a statewide basis.
- The Department will issue a Request for Proposal for services providing technical assistance to providers preparing to meet AIU and/or MU objectives. The need for assistance is related to the discontinuance of the Regional Extension Centers which currently provide technical support to providers participating in the Medi-Cal EHR Incentive Program.
- The Department will contract with the University of California, San Francisco (UCSF) under an Interagency Agreement to conduct a qualitative Ambulatory Care study which will build on prior work performed by the contract Investigators. The study will fill important gaps in information necessary for policymakers and providers using EHR in California.
- The Department will contract with UCSF to conduct periodic surveys over the course of the EHR Incentive Program which are required to refine the initial landscape assessment and to document activities currently underway or in the planning phase. The California Physicians' Use of EHR surveys will be used to facilitate Health Information Exchange and EHR adoption for Medi-Cal.

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

Additional projects (CalREDIE, Provider Technical Assistance, Ambulatory Care Study and the California Physicians' Use of EHR) will be administered.

### **Methodology:**

1. For the CAIR 2.0 and CalREDIE projects, the 10% non-federal share is budgeted by CDPH. This policy change budgets the Title XIX 90% FFP that will be provided to CDPH for the CAIR 2.0 and CalREDIE contracts through an interagency agreement.
2. The ARRA HITECH Incentive Program is eligible for 90% FFP. Currently, 14 separate projects are in place to assess the administration of HITECH. In FY 2013-14 and FY 2014-15, the 10% non-federal share for the Provider Technical Assistance, Ambulatory Care Study, California Physicians' Use of EHR and other projects will be provided by outside entities.
3. Xerox projects are eligible for ARRA HITECH funding under the FI contract.

**ARRA HITECH INCENTIVE PROGRAM**

OTHER ADMIN. POLICY CHANGE NUMBER: 11

<b>FY 2013-14:</b>	<b>TF</b>	<b>Reimbursement</b>	<b>FF</b>
CAIR 2.0 (100% Reimbursement)	\$735,000	\$0	\$735,000
CalREDIE (100% Reimbursement)	\$636,000	\$0	\$636,000
Provider Technical Assistance (90% FF/10% GF)	\$17,500,000	\$1,750,000	\$15,750,000
Ambulatory Care Study (90% FF/10% GF)	\$500,000	\$50,000	\$450,000
CA Physicians' Use of EHR (90% FF/10% GF)	\$300,000	\$30,000	\$270,000
Other projects (90% FF/10% GF)	\$1,535,000	\$154,000	\$1,381,000
<b>Total</b>	<b>\$21,206,000</b>	<b>\$1,984,000</b>	<b>\$19,222,000</b>
	<b>TF</b>	<b>GF</b>	<b>FF</b>
Xerox projects (In FI Estimate)	\$3,200,000	\$320,000	\$2,880,000
Total FY 2013-14	\$24,406,000	\$2,304,000	\$22,102,000
	<b>TF</b>	<b>Reimbursement</b>	<b>FF</b>
<b>FY 2014-15:</b>			
CAIR 2.0 (100% Reimbursement)	\$1,554,000	\$0	\$1,554,000
CalREDIE (100% Reimbursement)	\$636,000	\$0	\$636,000
Provider Technical Assistance (90% FF/10% GF)	\$32,500,000	\$3,250,000	\$29,250,000
Other projects (90% FF/10% GF)	\$1,535,000	\$154,000	\$1,381,000
<b>Total</b>	<b>\$36,225,000</b>	<b>\$3,404,000</b>	<b>\$32,821,000</b>
	<b>TF</b>	<b>GF</b>	<b>FF</b>
Xerox projects (In FI Estimate)	\$800,000	\$80,000	\$720,000
Total FY 2014-15	\$37,025,000	\$3,484,000	\$33,541,000

**Funding:**

90% Title XIX / 10% GF (4260-101-0001/0890)

100% Reimbursement (4260-601-0995)

## POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 12  
 IMPLEMENTATION DATE: 7/1993  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 231

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$19,245,000	\$17,832,000
STATE FUNDS	\$9,713,500	\$9,019,500
FEDERAL FUNDS	\$9,531,500	\$8,812,500

### DESCRIPTION

**Purpose:**

This policy change budgets postage and printing costs for items sent to or used by Medi-Cal beneficiaries.

**Authority:**

Welfare & Institutions Code 14007.71

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees, and at least every 3 years to existing beneficiaries. Postage and printing costs for the HIPAA NPP, Quarterly JvR ("Your Fair Hearing Rights"), Incarceration Verification Program (IVP), Earned Income Tax Credit (EITC), and Public Assistance Reporting Information System (PARIS) are included in this item.

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are 100% GF and Healthy Families are 35% GF/65% FFP.

**Reason for Changes from Prior Estimate:**

Cost reductions due to discontinuation of monthly charges for toll-free postage and elimination of the Transitional Medi-Cal Flyer mailing.

**POSTAGE & PRINTING**

OTHER ADMIN. POLICY CHANGE NUMBER: 12

**Methodology:**

- Estimated costs were provided by the Medi-Cal Eligibility Division (MCED).

(Dollars in Thousands)

<b>FY 2013-14</b>	<b>Printing</b>	<b>Mailing</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Mass Mailings	\$0	\$8,000	\$8,000	\$4,000	\$4,000
Eligibility					
Distribution	\$0	\$520	\$520	\$260	\$260
Routine	\$2,400	\$600	\$3,000	\$1,500	\$1,500
EITC Annual insert*	\$175	\$0	\$175	\$175	\$0
PARIS	\$154	\$46	\$200	\$100	\$100
Incarceration Verification Program	\$39	\$12	\$51	\$26	\$26
Benefits	\$600	\$1,000	\$1,600	\$800	\$800
BCCTP (35% State-Only Eligs)	\$5	\$16	\$21		
*35% State-Only	\$0	\$0	\$0	\$7	\$0
65% 50/50 Split	\$0	\$0	\$0	\$7	\$7
HIPAA NPP - M/C	\$2,200	\$2,000	\$4,200	\$2,100	\$2,100
HIPAA NPP - FPACT	\$150	\$100	\$250	\$125	\$125
HIPAA NPP - BCCTP	\$30	\$10	\$40	\$20	\$20
ACA Express Lane Enrollment	\$793	\$395	\$1,188	\$594	\$594
<b>TOTAL (Rounded)</b>	<b>\$6,546</b>	<b>\$12,699</b>	<b>\$19,245</b>	<b>\$9,714</b>	<b>\$9,531</b>

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>Printing</b>	<b>Mailing</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Mass Mailings	\$0	\$8,000	\$8,000	\$4,000	\$4,000
Eligibility					
Distribution	\$0	\$520	\$520	\$260	\$260
Routine	\$2,400	\$600	\$3,000	\$1,500	\$1,500
EITC Annual insert*	\$200	\$0	\$200	\$200	\$0
PARIS	\$154	\$46	\$200	\$100	\$100
Incarceration Verification Program	\$39	\$12	\$51	\$26	\$26
Benefits	\$600	\$1,000	\$1,600	\$800	\$800
BCCTP (35% State-Only Eligs)	\$5	\$16	\$21		
*35% State-Only	\$0	\$0	\$0	\$7	\$0
65% 50/50 Split	\$0	\$0	\$0	\$7	\$7
HIPAA NPP - M/C	\$2,200	\$2,000	\$4,200	\$2,100	\$2,100
HIPAA NPP - FPACT	\$0	\$0	\$0	\$0	\$0
HIPAA NPP - BCCTP	\$30	\$10	\$40	\$20	\$20
<b>TOTAL (Rounded)</b>	<b>\$5,628</b>	<b>\$12,204</b>	<b>\$17,832</b>	<b>\$9,020</b>	<b>\$8,812</b>

**Funding:**

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

100 % GF (4260-101-0001)\*

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

## ACA EXPANSION ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 13  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1795

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$16,825,000	\$8,325,000
STATE FUNDS	\$8,412,500	\$4,162,500
FEDERAL FUNDS	\$8,412,500	\$4,162,500

### DESCRIPTION

**Purpose:**

This policy change estimates the contract costs for implementing required provisions of the Affordable Care Act (ACA).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Effective January 1, 2014, Medicaid will be expanded to include individuals between the ages of 19 up to 65 (primarily childless adults) with incomes up to 138% of the federal poverty level based on modified adjusted gross income. 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 the uninsured. These mandatory requirements will encourage many individuals who are currently eligible but not enrolled to enroll in Medi-Cal.

This policy change estimates the contract costs associated with IT consultant services, system modifications, postage and printing costs, actuarial work for rate development, and other miscellaneous costs.

**Reason for Change from Prior Estimate:**

Estimated costs related to consultant and actuarial work were reduced.

**Methodology:**

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

**ACA EXPANSION ADMIN COSTS**  
**OTHER ADMIN. POLICY CHANGE NUMBER: 13**

(Dollars in Thousands)

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
System Changes	\$4,000	\$2,000	\$2,000
Postage and Printing	\$11,400	\$5,700	\$5,700
Consultant Services	\$1,425	\$713	\$713
<b>Total</b>	<b>\$16,825</b>	<b>\$8,413</b>	<b>\$8,413</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
System Changes	\$2,000	\$1,000	\$1,000
Postage and Printing	\$5,700	\$2,850	\$2,850
Consultant Services	\$625	\$313	\$313
<b>Total</b>	<b>\$8,325</b>	<b>\$4,163</b>	<b>\$4,163</b>

**Funding:**

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

## COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 14  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1729

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$16,558,000	\$17,203,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$16,558,000	\$17,203,000

### DESCRIPTION

**Purpose:**

This policy change estimates the county utilization review (UR) and quality assurance (QA) administrative costs.

**Authority:**

Welfare & Institutions Code 14711

**Interdependent Policy Changes:**

Not Applicable

**Background:**

UR and QA activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 75% for skilled medical personnel and 50% for all other personnel claims.

**Reason for Change from Prior Estimate:**

The percentage of payments made during each fiscal year has been updated based on historical paid claims data.

**Methodology:**

1. UR and QA expenditures are shared between federal funds (FFP) and county funds (CF).
2. UR and QA costs are based on historical trends. UR and QA costs on an accrual basis are:

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
FY 2012-13	\$25,271	\$16,455	\$8,816
FY 2013-14	\$25,957	\$16,901	\$9,056
FY 2014-15	\$26,740	\$17,411	\$9,329

**COUNTY UR & QA ADMIN**

OTHER ADMIN. POLICY CHANGE NUMBER: 14

3. Based on historical claims received, assume 60% of the each fiscal year claims will be paid in the year the services occur. Assume 39% is paid in the following year and 1% is paid in the third year.

(Dollars in Thousands)

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2013-14</u>	<u>FY 2014-15</u>
FY 2012-13	\$25,271	\$9,856	\$253
FY 2013-14	\$25,957	\$15,574	\$10,123
FY 2014-15	\$26,740	\$0	\$16,044
Total		\$25,430	\$26,420

4. Skilled professional medical personnel (SPMP) are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.
5. Based on historical claims received, assume 40% of the total claims are Other personnel costs and the remaining 60% are SPMP.

(Dollars in Thousands)

<u>Personnel</u>	<u>TF</u>	<u>FY 2013-14</u>		<u>TF</u>	<u>FY 2014-15</u>	
		<u>FFP</u>	<u>CF</u>		<u>FFP</u>	<u>CF</u>
Other	\$10,058	\$5,029	\$5,029	\$10,449	\$5,225	\$5,225
Medical	\$15,372	\$11,529	\$3,843	\$15,971	\$11,978	\$3,993
<b>Total</b>	<b>\$25,430</b>	<b>\$16,558</b>	<b>\$8,872</b>	<b>\$26,420</b>	<b>\$17,203</b>	<b>\$9,217</b>

**Funding:**

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

## MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 15  
 IMPLEMENTATION DATE: 7/2002  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 252

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$10,900,000	\$10,900,000
STATE FUNDS	\$2,892,750	\$2,897,000
FEDERAL FUNDS	\$8,007,250	\$8,003,000

### DESCRIPTION

**Purpose:**

The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The MIS/DSS houses a variety of Medicaid-related data and incorporates it into an integrated, business intelligence system. The system is used by the Department and other approved entities. The Department uses the system in various ways, including:

- The Medi-Cal Managed Care Division in its monitoring of Health Plan performance,
- The Third Party Liability and Recovery Division in its collection efforts, and
- The Audits and Investigations Division in its anti-fraud efforts.

Ongoing enhancement, operation and maintenance of the MIS/DSS are accomplished through a multi-year contract, which is effective through February 14, 2014. The Department plans to extend the current contract period through June 30, 2015.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. It is estimated that the contractor will be paid the following amounts in FY 2013-14 and FY 2014-15:

	TF	GF	FF
<b>FY 2013-14:</b>			
Fixed Costs (75% FF / 25% GF)	\$7,592,000	\$1,898,000	\$5,694,000
Additional Fixed Costs (50% FF / 50% GF)	\$671,000	\$335,500	\$335,500
Variable Costs (75% FF / 25% GF)	\$2,637,000	\$659,500	\$1,977,500
<b>Total</b>	<b>\$10,900,000</b>	<b>\$2,893,000</b>	<b>\$8,007,000</b>

**MIS/DSS CONTRACT**

OTHER ADMIN. POLICY CHANGE NUMBER: 15

<b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Fixed Costs (75% FF / 25% GF)	\$7,403,000	\$1,851,000	\$5,552,000
Additional Fixed Costs (50% FF / 50% GF)	\$688,000	\$344,000	\$344,000
Variable Costs (75% FF / 25% GF)	\$2,809,000	\$702,000	\$2,107,000
<b>Total</b>	<b>\$10,900,000</b>	<b>\$2,897,000</b>	<b>\$8,003,000</b>

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0001/0890)

## LITIGATION RELATED SERVICES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 16  
**IMPLEMENTATION DATE:** 7/2009  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 1381

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$9,980,000	\$9,980,000
STATE FUNDS	\$4,990,000	\$4,990,000
FEDERAL FUNDS	\$4,990,000	\$4,990,000

### DESCRIPTION

**Purpose:**

This policy change estimates the costs of litigation and actuarial consulting.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department continues to experience an increase in the number and complexity of litigation cases challenging legislation implementing changes to the Medi-Cal program. As a result, the Department of Justice costs and other litigation support costs have increased from previous years.

Several significant cases, which had previously been inactive awaiting a precedential decision by the United States Supreme Court, continue to be active. Also, ongoing litigation filed by managed care plans relating to capitation rates has resulted in significant time expended by actuarial staff in evaluating the cases and developing defense strategies.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be \$7,880,000 for FY 2013-14, and \$7,880,000 for FY 2014-15.
2. Based on prior actuary costs and the Department's projected workload, costs will be \$2,100,000 in FY 2013-14 and \$2,100,000 in FY 2014-15.

**LITIGATION RELATED SERVICES**

OTHER ADMIN. POLICY CHANGE NUMBER: 16

	FY 2013-14		FY 2014-15	
	TF	GF	TF	GF
Litigation Representation	\$ 7,880,000	\$ 3,940,000	\$ 7,880,000	\$ 3,940,000
Consulting Actuaries	\$ 2,100,000	\$ 1,050,000	\$ 2,100,000	\$ 1,050,000
<b>Total</b>	<b>\$ 9,980,000</b>	<b>\$ 4,990,000</b>	<b>\$ 9,980,000</b>	<b>\$ 4,990,000</b>

**Funding:**

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

## CCI - DUAL ELIGIBLE DEMONSTRATION PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 17  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1677

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$8,786,000	\$8,070,000
STATE FUNDS	\$2,543,000	\$2,543,000
FEDERAL FUNDS	\$6,243,000	\$5,527,000

### DESCRIPTION

**Purpose:**

This policy change estimates the administrative costs for the Coordinated Care Initiative (CCI).

**Authority:**

SB 1008 (Chapter 33, Statutes of 2012)  
 SB 1036 (Chapter 45, Statutes of 2012)  
 SB 94 (Chapter 37, Statutes of 2013)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

In coordination with Federal and State Government, the CCI will provide benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles). CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services and institutional long-term care services. Services will be provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. The Department will be hiring contractors to do the following:

- Stakeholder and advocate outreach,
- Rate setting,
- Medicare and Medi-Cal data analysis,
- Quality assurance and monitoring by an External Quality Review Organization (EQRO),
- Beneficiary and Provider Outreach,
- IT Project Management, and
- Data Outcomes and Evaluation Development.

**Reason for Change from Prior Estimate:**

In September, the Department received approval from CMS for a \$15 million dollar grant to implement the Dual Eligible Demonstration program. A portion of the grant funding is included in this policy change in FY 2013-14 and FY 2014-15.

**Methodology:**

1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2015-16.

**CCI - DUAL ELIGIBLE DEMONSTRATION PROJECT**

OTHER ADMIN. POLICY CHANGE NUMBER: 17

2. The Affordability Care Act (ACA) authorizes funding for the CCI and provides 100% federal financial participation (FFP) to carry out the deliverables between the Department and Centers for Medicare and Medicaid.

<b>2013-14 Costs</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>ACA FFP</b>
Stakeholder and Advocate Outreach	\$5,072,000	\$2,536,000	\$2,536,000	\$0
Rate Setting	\$510,000	\$0	\$0	\$510,000
Data Analysis	\$250,000	\$0	\$0	\$250,000
Beneficiary Outreach	\$0	\$0	\$0	\$0
Provider Outreach	\$0	\$0	\$0	\$0
IT Costs	\$43,000	\$0	\$0	\$43,000
Encounter Data Quality & Perform. Measures	\$295,000	\$0	\$0	\$295,000
EQRO Monitoring	\$1,900,000	\$0	\$0	\$1,900,000
Ombudsman Activities	\$401,000	\$7,000	\$7,000	\$387,000
Data Translations	\$315,000	\$0	\$0	\$315,000
<b>Total</b>	<b>\$8,786,000</b>	<b>\$2,543,000</b>	<b>\$2,543,000</b>	<b>\$3,700,000</b>

<b>2014-15 Costs</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>	<b>ACA FFP</b>
Stakeholder and Advocate Outreach	\$3,816,000	\$1,908,000	\$1,908,000	\$0
Rate Setting	\$510,000	\$0	\$0	\$510,000
Data Analysis	\$250,000	\$0	\$0	\$250,000
Beneficiary Outreach	\$0	\$0	\$0	\$0
Provider Outreach	\$0	\$0	\$0	\$0
IT Costs	\$9,000	\$0	\$0	\$9,000
Encounter Data Quality & Perform. Measures	\$0	\$0	0	\$0
EQRO Monitoring	\$1,900,000	\$0	\$0	\$1,900,000
Ombudsman Activities	\$1,270,000	\$635,000	\$635,000	\$0
Data Translations	\$315,000	\$0	\$0	\$315,000
<b>Total</b>	<b>\$8,070,000</b>	<b>\$2,543,000</b>	<b>\$2,543,000</b>	<b>\$2,984,000</b>

**Funding:**

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

100% Title XIX Federal Share (4260-101-0890)

## CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 18  
 IMPLEMENTATION DATE: 5/2010  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1322

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$7,837,000	\$3,644,000
STATE FUNDS	\$1,560,300	\$539,550
FEDERAL FUNDS	\$6,276,700	\$3,104,450

### DESCRIPTION

**Purpose:**

This policy change estimates the transition cost related to replacement and transition of the California Medicaid Management Information System (CA-MMIS).

**Authority:**

Title XIX of the Federal Social Security Act 1903(a)(3)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CA-MMIS is the claims processing system used for Medi-Cal. The transition costs incurred for CA-MMIS Replacement activities include interfacing with other Departmental mission critical systems such as Medi-Cal Eligibility Data System, Enhanced Medi-Cal Budget Estimate Redesign, State Controller's Office, Management Information System and Decision Support System, California Healthcare Eligibility, Enhancement and Retention System and Paid Claims and Encounters Standardization applications that require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system, user acceptance and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Replacement phase. The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during the Replacement phase. Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS Replacement phase.

**Reason for Change from Prior Estimate:**

In FY 2013-14, contract costs increased due to newly executed contracts that were not in place in the prior estimate.

**Methodology:**

1. Advanced planning documents for these activities provide the basis for these estimates.

## CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 18

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$35,000	\$17,500	\$17,500
75% Title XIX / 25% GF	\$4,142,000	\$1,035,000	\$3,107,000
90% Title XIX / 10% GF	\$3,503,000	\$350,500	\$3,152,500
100% GF	\$157,000	\$157,000	\$0
<b>Total</b>	<b>\$7,837,000</b>	<b>\$1,560,000</b>	<b>\$6,277,000</b>

<b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$16,000	\$8,000	\$8,000
75% Title XIX / 25% GF	\$687,000	\$172,000	\$515,000
90% Title XIX / 10% GF	\$2,868,000	\$287,000	\$2,581,000
100% GF	\$73,000	\$73,000	\$0
<b>Total</b>	<b>\$3,644,000</b>	<b>\$540,000</b>	<b>\$3,104,000</b>

**Funding:**

50% Title XIX / 50% GF (4260-101-0001/0890)  
 75% Title XIX / 25% GF (4260-101-0001/0890)  
 90% Title XIX / 10% GF (4260-101-0001/0890)  
 100% GF (4260-101-0001)

## CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER: 19  
 IMPLEMENTATION DATE: 10/2007  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1278

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$6,368,000	\$6,290,000
STATE FUNDS	\$973,150	\$753,600
FEDERAL FUNDS	\$5,394,850	\$5,536,400

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of contractors who assist with the oversight of the replacement of the California Medicaid Management Information System (CA-MMIS).

**Authority:**

Title XIX of the Federal Social Security Act 1903(a)(3)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CA-MMIS is the claims processing system used for Medi-Cal. Given the business critical nature of CA-MMIS, a detailed assessment was completed and the recommendation was to immediately modernize CA-MMIS. The Department contracts with various vendors to assist with highly specialized Fiscal Intermediary oversight activities, documentation of business rules, technical architecture, federal certification management, project management, transition management, and independent verification and validation services during transition and replacement of the CA-MMIS system.

**Reason for Change from Prior Estimate:**

In FY 2013-14, costs increased due to newly executed contracts that were not in place in the prior estimate.

**Methodology:**

- The estimated costs are based upon the contract provisions.

FY 2013-14:	TF	GF	FF
50% Title XIX / 50% GF	\$29,000	\$14,500	\$14,500
75% Title XIX / 25% GF	\$1,403,000	\$350,500	\$1,052,500
90% Title XIX / 10% GF	\$4,809,000	\$481,000	\$4,328,000
100% GF	\$127,000	\$127,000	\$0
<b>Total</b>	<b>\$6,368,000</b>	<b>\$973,000</b>	<b>\$5,395,000</b>

**CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT**

OTHER ADMIN. POLICY CHANGE NUMBER: 19

<b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF	\$28,000	\$14,000	\$14,000
90% Title XIX / 10% GF	\$6,136,000	\$614,000	\$5,523,000
100% GF	\$126,000	\$126,000	\$0
<b>Total</b>	<b>\$6,290,000</b>	<b>\$754,000</b>	<b>\$5,537,000</b>

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0001/0890)

90% Title XIX / 10% GF (4260-101-0001/0890)

100% GF (4260-101-0001)

## ADHC TRANSITION-ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 20  
 IMPLEMENTATION DATE: 1/2012  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 1638

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$6,172,000	\$0
STATE FUNDS	\$3,086,000	\$0
FEDERAL FUNDS	\$3,086,000	\$0

### DESCRIPTION

**Purpose:**

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

**Authority:**

AB 97 (Chapter 3, Statutes of 2011)  
*Esther Darling, et al. v. Toby Douglas, et al.* settlement agreement

**Interdependent Policy Changes:**

Not Applicable

**Background:**

AB 97 eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et al. v. Toby Douglas, et al.*, sought to challenge the elimination of ADHC services. A settlement of the lawsuit was reached that established the CBAS program.

**Reason for Change from Prior Estimate:**

All fair hearing penalty payments were not made in the prior year as anticipated. The estimate was revised to include costs for additional staff to conduct the fair hearings. The actual costs for Fee-for-Service (FFS) Assessment and Care Coordination have been updated based upon current invoices.

**Methodology:**

FFS Assessment and Care Coordination—For those ADHC clients in counties without managed care or when the client was not eligible for CBAS, the Department contracted with APS, Inc., through July 31, 2013, to provide care coordination and case management for community-based services.

Fair Hearings—For beneficiaries found ineligible for CBAS during their assessment process, fair hearings were conducted. These costs are incurred by the Department for fair hearing outcomes and penalties. 2,376 fair hearings have been conducted as of July 2013, of which, 1,237 were found eligible for CBAS, 257 were found ineligible for CBAS and 865 withdrew from the fair hearing process.

Administrative Law Judges—Due to the unexpected volume of fair hearings, the Department agreed to pay for additional Administrative Law Judges to conduct the hearings for the period of December 2012 through June 2013.

**ADHC TRANSITION-ADMINISTRATION**

OTHER ADMIN. POLICY CHANGE NUMBER: 20

(Dollars in Thousands)

	FY 2013-14	
	<u>TF</u>	<u>GF</u>
FFS Assessment & Care Coordination	\$87	\$43
Fair Hearing Costs	\$2,082	\$1,041
Administrative Law Judge Costs	<u>\$4,002</u>	<u>\$2,001</u>
Total	<b>\$6,171</b>	<b>\$3,085</b>

**Funding:**

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

## MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 21  
 IMPLEMENTATION DATE: 7/2009  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1441

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$5,631,000	\$5,913,000
STATE FUNDS	\$1,889,000	\$1,983,750
FEDERAL FUNDS	\$3,742,000	\$3,929,250

### DESCRIPTION

**Purpose:**

This policy change estimates the maintenance expenditures and reimbursements for the Medi-Cal Eligibility Data System (MEDS), the statewide database containing eligibility information for public assistance programs administered by the Department and other departments.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status. Funding is required for the following:

- MEDS Master Client Index maintenance,
- Data matches from various federal and state agencies,
- Supplemental Security Income termination process support,
- Medi-Cal application alerts,
- Medicare Modernization Act Part D buy-in process improvements,
- Eligibility renewal process, and
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities.

In addition, maintenance funding is required for the Business Objects software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. Costs are offset by reimbursements made from other departments.

**Reason for Change from Prior Estimate:**

Projections were revised based on additional actual expenditures.

**Methodology:**

1. The following projections are based on actual data from July 2012 through February 2013.

**MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)**

OTHER ADMIN. POLICY CHANGE NUMBER: 21

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
(50% FF / 50% GF)	\$860,000	\$430,000	\$430,000
(75% FF / 25% GF)	\$4,416,000	\$1,104,000	\$3,312,000
(100% Reimbursement)	\$355,000	\$355,000	\$0
<b>Total</b>	<b>\$5,631,000</b>	<b>\$1,889,000</b>	<b>\$3,742,000</b>
<b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
(50% FF / 50% GF)	\$903,000	\$451,500	\$451,500
(75% FF / 25% GF)	\$4,637,000	\$1,159,000	\$3,478,000
(100% Reimbursement)	\$373,000	\$373,000	\$0
<b>Total</b>	<b>\$5,913,000</b>	<b>\$1,983,500</b>	<b>\$3,929,500</b>

**Funding:**

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

75% Title XIX / 25% GF (4260-101-0001/0890)

100% Reimbursement (4260-601-0995)

## MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 22  
 IMPLEMENTATION DATE: 2/2008  
 ANALYST: Raman Pabla  
 FISCAL REFERENCE NUMBER: 1551

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$5,290,000	\$5,709,000
STATE FUNDS	\$1,322,500	\$1,427,250
FEDERAL FUNDS	\$3,967,500	\$4,281,750

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of the health insurance (HI) contracts to identify recipients with third party health insurance coverage and workers' compensation (WC) insurance. The policy change also includes online database contracts to access online activity and data matches in support of recovery.

**Authority:**

Contracts

Business Information Services, Inc.	12-89078
Department of Industrial Relations (EAMS)	09-86353 A01
Department of Social Services	10-87009 A01
Health Management Systems Inc. (HI)	08-85000 A02
Health Management Systems Inc. (HI)	13-90283
Health Management Systems Inc. (WC)	03-75807
Health Management Systems Inc. (WC)	03-75060
Health Management Systems Inc. (WC)	07-65000 A03
Health Management Systems Inc. (WC)	07-65001 A03
Health Management Systems Inc. (WC)	12-89100
Health Management Systems Inc. (WC)	12-89101
Lexis-Nexis	11-88003
Boehm & Associates	97-10689
Boehm & Associates	97-10690

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Since Medi-Cal is the payer of last resort, other health plans must first be billed before the Medi-Cal program. The contracts provide:

1. Data matches between the Department's Medi-Cal Recipient Eligibility file and the contractor's policy holder/subscriber file;
2. Identification and recovery of Medi-Cal expenditures in workers' compensation actions;

**MEDI-CAL RECOVERY CONTRACTS****OTHER ADMIN. POLICY CHANGE NUMBER: 22**

3. Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer;
4. Online access to research database services for public records of Medi-Cal recipients; and
5. Cost avoidance activities.

When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries. Recoveries due to workers' compensation vendor activities are budgeted in the Base Recoveries policy change. Recoveries due to health insurance vendor activities are incorporated into the base estimate.

The current contract for health insurance began December 1, 2008 and ends November 30, 2013. The new health insurance contract was awarded to Health Management Systems with an effective date of December 1, 2013 and ends on November 30, 2018.

The new worker's compensation contract was awarded Health Management Systems with an effective date of May 1, 2013 and ends on April 30, 2017.

**Reason for Change from Prior Estimate:**

The new health insurance contract increased the contingency fee from 6.4% to 8.5%.

**Methodology:**

1. The amounts paid to the contractors are based upon recoveries. The payments shown below include recent recovery activity.

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
Health Insurance	\$4,757,000	\$1,189,000	\$3,568,000
Workers' Compensation	\$453,000	\$113,000	\$340,000
Online Database Contracts	\$80,000	\$20,000	\$60,000
<b>Total</b>	<b>\$5,290,000</b>	<b>\$1,322,000</b>	<b>\$3,968,000</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FFP</b>
Health Insurance	\$5,100,000	\$1,275,000	\$3,825,000
Workers' Compensation	\$529,000	\$132,000	\$397,000
Online Database Contracts	\$80,000	\$20,000	\$60,000
<b>Total</b>	<b>\$5,709,000</b>	<b>\$1,427,000</b>	<b>\$4,282,000</b>

**Funding:**

75% Title XIX / 25% GF (4260-101-0001/0890)

## COORDINATED CARE MANAGEMENT PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 23  
 IMPLEMENTATION DATE: 2/2010  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1125

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$4,716,000	\$118,000
STATE FUNDS	\$2,358,000	\$59,000
FEDERAL FUNDS	\$2,358,000	\$59,000

### DESCRIPTION

**Purpose:**

This policy change estimates the costs for the Coordinated Care Management (CCM) Pilot Project.

**Authority:**

The Budget Act of 2006

**Interdependent Policy Change:**

Not Applicable

**Background:**

The CCM Pilot Project consisted of two pilot programs designed to improve healthcare outcomes and achieve cost containment in the fee-for-service (FFS) Medi-Cal System. The CCM Pilot Project was cost neutral and provided care coordination for FFS beneficiaries by a contractor.

Key elements of the CCM Pilot Project include maintaining access to medically necessary and appropriate services, improving health, and providing care in a more cost-effective manner for two populations enrolled in the FFS Medi-Cal Program who were not on Medicare:

- CCM 1 - Seniors and persons with disabilities who had chronic conditions, or who may have been seriously ill and near the end of life. CCM-1 was completed with the transition of the Seniors and Persons with Disabilities population into Medi-Cal managed care health plans; and
- CCM 2 - Persons with chronic health condition(s) and serious mental illnesses (SMI). The SMI scope of work expired on July 31, 2013. This contract was amended to include Adult Day Health Care (ADHC) scope of work services to transition eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit. The CBAS scope of work was terminated in the contract on July 31, 2013 with the transition of services to the Department's Long Term Care Division.

The Department entered into two contracts with APS Healthcare to implement the CCM Pilot Project. CCM 1 began operations in January 2010, with payments for services beginning in February 2010. CCM 2 began operations in April 2010, with payments for services beginning in May 2010. The University of California, Los Angeles (UCLA) was contracted to conduct an independent evaluation (IE) of the CCM Pilot Project. The UCLA IE startup cost for both CCM Pilot Projects will begin in December 2012.

The contract term for CCM 1 was from March 1, 2009 to December 31, 2012. The contract term for CCM 2 was from August 20, 2009 to August 31, 2014. However, the CCM 2 contract terminated 13

**COORDINATED CARE MANAGEMENT PILOT**

OTHER ADMIN. POLICY CHANGE NUMBER: 23

months earlier on July 31, 2013. The contract term for UCLA IE is from December 1, 2012 through January 30, 2015.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

ADHC FFS Assessment and Care Coordination costs are reflected in the ADHC Transition Administration policy change.

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CCM1	\$0	\$0	\$0
CCM2	\$4,612,000	\$2,306,000	\$2,306,000
UCLA IE	\$104,000	\$52,000	\$52,000
<b>Total</b>	<b>\$4,716,000</b>	<b>\$2,358,000</b>	<b>\$2,358,000</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
CCM1	\$0	\$0	\$0
CCM2	\$0	\$0	\$0
UCLA IE	\$118,000	\$59,000	\$59,000
<b>Total</b>	<b>\$118,000</b>	<b>\$59,000</b>	<b>\$59,000</b>

**Funding:**

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

## RESTORATION OF SELECT ADULT DENTAL BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 24  
 IMPLEMENTATION DATE: 5/2014  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1800

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$905,000	\$19,906,000
STATE FUNDS	\$286,000	\$6,275,000
FEDERAL FUNDS	\$619,000	\$13,631,000

### DESCRIPTION

**Purpose:**

This policy change estimates the administrative costs to restore partial adult optional dental benefits.

**Authority:**

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

**Interdependent Policy Changes:**

PC 38 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 percent 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 administrative 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 eligibles for optional ACA for May 2014 to June 2014 decreased. The estimate for FY 2014-15 is for a complete year.

**Methodology:**

1. Assume the implementation date is May 2014.

## RESTORATION OF SELECT ADULT DENTAL BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 24

2. In FY 2013-14 and FY 2014-15, 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

(Dollars in Thousands)

	TF	FFP	GF
<b>Administrative Costs (FI)</b>			
Current Medi-Cal	\$373	\$255	\$118
ACA Mandatory Expansion	\$178	\$122	\$56
ACA Optional Expansion	\$354	\$242	\$112
<b>Total Administrative Costs (FI)</b>	<b>\$905</b>	<b>\$619</b>	<b>\$286</b>

### FY 2014-15

(Dollars in Thousands)

	TF	FFP	GF
<b>Administrative Costs (FI)</b>			
Current Medi-Cal	\$8,212	\$5,623	\$2,589
ACA Mandatory Expansion	\$3,911	\$2,678	\$1,233
ACA Optional Expansion	\$7,783	\$5,330	\$2,453
<b>Total Administrative Costs (FI)</b>	<b>\$19,906</b>	<b>\$13,631</b>	<b>\$6,275</b>

### Funding:

100% General Fund (4260-101-0001)

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

## PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 25  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1720

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$3,366,000	\$6,400,000
STATE FUNDS	\$841,500	\$1,600,000
FEDERAL FUNDS	\$2,524,500	\$4,800,000

### DESCRIPTION

**Purpose:**

This policy change estimates the contract cost for QTC Medical Group and estimates the cost to fund an IT project to design, test, and implement a web based automated system to bring Preadmission Screening and Resident Review (PASRR) into compliance with federal mandates.

**Authority:**

Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Federal regulations mandate that the Department have an independent contractor complete all Level II PASRR Evaluations. QTC Medical Group, Inc. completes Level II evaluations for the federally mandated PASRR program. A Level II evaluation consists of a face to face mental status examination and psychosocial assessment for individuals identified with mental illness upon admission to a nursing facility. The findings of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. QTC's licensed clinical evaluators conduct the Level II evaluations on behalf of the State and enter their findings into the PASRR database.

The FY 2012-13 budget was included in the Department's support budget, but beginning FY 2013-14 it is currently part of the Department's local assistance estimate. The new contract will begin in July 2014. PASRR will release a bid for FY 2014-15 through FY 2017-18 (with an option to renew for two additional years) for the Level II evaluations.

PASRR received funding to design, test, and implement a web based automated system to bring the preadmission Level I Screening, Level II evaluation, and Level II determination processes into compliance with federally mandated regulations for PASRR. The IT project will replace an inefficient mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The Department will save money by not contracting with a consultant to support the current mainframe and by hosting the new application in-house. The new IT system will:

- Be in compliance with federal mandates related to PASRR,
- Allow multiple agencies to submit electronic screening documents,
- Significantly reduce processing time for submissions,
- Eliminate paper submissions,

**PASRR****OTHER ADMIN. POLICY CHANGE NUMBER: 25**

- Reduce the time a contractor takes to return completed evaluations, and
- Increase efficiencies for PASRR clinicians by reducing processing time for determinations.

**Reason for Change from Prior Estimate:**

Due to a delay in the project, 25% of the estimated IT project cost will carry over to FY 2014-15.

**Methodology:**

1. There was a 60% increase in the number of completed Level II evaluations returned by the Contractor in FY 2012-13. The IT project will allow preadmission screening to be conducted as mandated and may significantly increase the number of Level II evaluations needed. This will result in a significant increase in the cost of the contract.
2. PASRR contract costs are eligible for enhanced federal reimbursement of 75% FF and 25% GF.
3. PASRR received \$1,000,000 for the IT project with 75% FF and 25% GF.
4. Assume 25% of the estimated IT project cost will carry over to FY 2014-15.
5. Assume the IT project requires maintenance and operations (M&O) costs of a \$150,000 annually. M&O costs are funded with 75% FF and 25% GF.

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Evaluations	\$2,616,000	\$654,000	\$1,962,000
IT Project	\$750,000	\$188,000	\$562,000
	<b>\$3,366,000</b>	<b>\$842,000</b>	<b>\$2,524,000</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Evaluations	\$6,000,000	\$1,500,000	\$4,500,000
IT Project	\$250,000	\$63,000	\$187,000
Ongoing M&O Costs	\$150,000	\$38,000	\$112,000
	<b>\$6,400,000</b>	<b>\$1,601,000</b>	<b>\$4,799,000</b>

**Funding:**

75% Title XIX / 25% GF (4260-101-0001/0890)

## ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 26  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1819

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$2,992,000	\$2,015,000
STATE FUNDS	\$1,022,000	\$1,003,750
FEDERAL FUNDS	\$1,970,000	\$1,011,250

### DESCRIPTION

**Purpose:**

This policy change estimates the contract costs for developing the web interface for 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 presumptive eligibility for Medicaid. A qualified hospital may elect to make presumptive eligibility determinations on the basis of preliminary information and according to policies and procedures established by the Department. The Department will permit presumptive eligibility 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 State anticipates that many of the eligible hospitals will participate. This policy changes estimates the contract costs for developing a simplified application form, online application and systems interfaces with MEDS.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

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

## ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

OTHER ADMIN. POLICY CHANGE NUMBER: 26

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. Of which, the Department estimates approximately 1.4% will be determined eligible through Hospital PE.
3. The Department estimates contract costs are **\$2,992,000 TF** in FY 2013-14 and **\$2,015,000 TF** in FY 2014-15.

### Funding:

<b>FY 2013-14</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$1,096,000	\$548,000	\$548,000
75% Title XIX / 25% GF (4260-101-0890/0001)	\$1,896,000	\$474,000	\$1,422,000
<b>Total</b>	<b>\$2,992,000</b>	<b>\$1,022,000</b>	<b>\$1,970,000</b>
<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$2,000,000	\$1,000,000	\$1,000,000
75% Title XIX / 25% GF (4260-101-0890/0001)	\$15,000	\$3,750	\$11,250
<b>Total</b>	<b>\$2,015,000</b>	<b>\$1,003,750</b>	<b>\$1,011,250</b>

## FAMILY PACT EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 27  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Randolph Alarcio  
 FISCAL REFERENCE NUMBER: 1674

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$2,861,000	\$2,861,000
STATE FUNDS	\$1,430,500	\$1,430,500
FEDERAL FUNDS	\$1,430,500	\$1,430,500

### DESCRIPTION

**Purpose:**

This policy change estimates the costs for data and evaluation of the Family Planning, Access, Care and Treatment (Family PACT) program.

**Authority:**

AB 1464 (Chapter 21, Statutes of 2012)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The University of California, San Francisco (UCSF) is conducting an evaluation of the Family PACT program. UCSF will evaluate the program's effectiveness, including the analysis of:

- Access by target populations,
- Changes in the provider base for target geographical areas,
- Provider compliance,
- Claims analysis, and
- Cost-effectiveness of services.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. The data and evaluation costs for the Family PACT program are estimated in the table below:

(Dollars in Thousands)

	TF	GF	FFP
FY 2013-14	\$2,861	\$1,431	\$1,431
FY 2014-15	\$2,861	\$1,431	\$1,431

**Funding:**

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

## PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 28  
 IMPLEMENTATION DATE: 2/2012  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1635

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$2,835,000	\$2,660,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,835,000	\$2,660,000

### DESCRIPTION

**Purpose:**

This policy change budgets the federal funds awarded to the Department by the Centers of Medicare and Medicaid Services (CMS) for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project.

**Authority:**

Affordable Care Act (ACA), Section 4108

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Section 4108 of the ACA authorizes the five-year MIPCD grant project. California's MIPCD proposal, Increasing Quitting among Medi-Cal Smokers, will use outreach and incentives to encourage access to smoking cessation services.

The Department contracts with the University of California, San Francisco (UCSF) to implement, run and evaluate the MIPCD program. The UCSF-hosted California Medicaid Research Institute provides administrative support, coordination of the key UC partners, and contracts directly with the University of California, San Diego (UCSD). UCSD operates the California Smokers' Helpline, which will offer various incentives, such as free counseling and nicotine replacement therapy, to Medi-Cal beneficiaries. The MIPCD project will also provide outreach to Medi-Cal beneficiaries and Medi-Cal providers via the California Diabetes Program, which is administered by the Department of Public Health and UCSF.

**Reason for Change from Prior Estimate:**

FY 2013-14 amounts increased due to a carryover of unused funds.

**Methodology:**

1. The Department was awarded the MIPCD grant on September 13, 2011 by CMS. A contract with UCSF was secured on January 27, 2012.
2. Projected costs are based on proposed contract amounts with UCSF for administration, implementation and evaluations associated with the MIPCD grant project.
3. On June 28, 2013, the Department submitted to CMS:
  - A \$940,843 carryover request of unspent funds from Project Year 2012-13 (September 13, 2012 – September 12, 2013), and

**PREVENTION OF CHRONIC DISEASE GRANT PROJECT**

OTHER ADMIN. POLICY CHANGE NUMBER: 28

- A \$2,524,740 continuation request for Project Year 2013-14 (September 13, 2013 – September 12, 2014).
4. A \$2,705,199 continuation request for Project Year 2014-15 (September 13, 2014 – September 12, 2015) is expected to be submitted to CMS in 2014.

**Cash Basis**

(Dollars in Thousands)

**FY 2013-14****TF****\$2,835****FFP****\$2,835****FY 2014-15****\$2,660****\$2,660****Funding:**

MIPCD Federal Grant (4260-107-0890)

## SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER: 29  
 IMPLEMENTATION DATE: 1/1989  
 ANALYST: Raman Pabla  
 FISCAL REFERENCE NUMBER: 237

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$2,420,000	\$2,662,000
STATE FUNDS	\$1,210,000	\$1,331,000
FEDERAL FUNDS	\$1,210,000	\$1,331,000

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

**Authority:**

Social Security Act 1634 (a)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

**Reason for Change from Prior Estimate:**

There is no material change.

**Methodology:**

1. The following projections are based upon recent actual billings from SSA.

(Dollars in Thousands)

FY 2012-13			FY 2013-14		
TF	GF	FFP	TF	GF	FFP
\$2,420	\$1,210	\$1,210	\$2,662	\$1,331	\$1,331

**Funding:**

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

## HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 30  
 IMPLEMENTATION DATE: 10/2012  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1318

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$2,016,000	\$2,487,000
STATE FUNDS	\$504,000	\$621,750
FEDERAL FUNDS	\$1,512,000	\$1,865,250

### DESCRIPTION

**Purpose:**

This policy change estimates the contract costs to make improvements, maintain, and operate the existing Health Insurance Portability and Accountability Act (HIPAA) Capitation Payment Reporting system (CAPMAN). The HIPAA imposes new transaction requirements (5010).

**Authority:**

45 CFR Part 162

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The CAPMAN system was implemented by the Department in July 2011. The HIPAA compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the beneficiary level while increasing the effectiveness of monthly reconciliations and supports research efforts to perform recoveries.

Due to the Affordable Care Act and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to prepare for the influx of new beneficiaries. Modifications will be made to further enhance the system to incorporate a paperless accounting interface and accommodate the Coordinated Care Initiative Duals Demonstration project. The system will have to be maintained on an ongoing basis, as new functionality is required. A new two-year contract was executed in July 2013, with optional 3 one-year extensions, to address these issues.

**Reason for Change from Prior Estimate:**

Costs increased due to contract being executed with up to date estimated amounts.

**Methodology:**

1. The contract costs will be \$4,503,000 with payments beginning in August 2013.
2. Costs for FY 2013-14 will total \$2,016,000 with the remaining balance of \$2,487,000 being paid in FY 2014-15.

**HIPAA CAPITATION PAYMENT REPORTING SYSTEM**

OTHER ADMIN. POLICY CHANGE NUMBER: 30

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Contract Costs	<u>\$2,016,000</u>	<u>\$504,000</u>	<u>\$1,512,000</u>
<b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Contract Costs	<u>\$2,487,000</u>	<u>\$622,000</u>	<u>\$1,865,000</u>

**Funding:**

75% Title XIX / 25% GF (4260-101-0001/0890)

## SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 31  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1732

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$1,500,000	\$1,959,000
STATE FUNDS	\$750,000	\$979,500
FEDERAL FUNDS	\$750,000	\$979,500

### DESCRIPTION

**Purpose:**

This policy change estimates the contractor's costs to perform the ongoing maintenance and operations support for the Short-Doyle/Medi-Cal (SDMC) system.

**Authority:**

Contract OHC-11-077

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The SDMC system adjudicates Medi-Cal claims for specialty mental health and substance use disorder services. On June 30, 2013, a contractor was hired for the ongoing maintenance and operation for this mission critical system. The term of the contract is one year. In FY 2014-15, the Department plans to execute a new contract for four years, with two one-year extensions.

**Reason for Change from Prior Estimate:**

The change is due to a delay in hiring the contractors.

**Methodology:**

1. The current one-year contract began in June 2013, and is for \$1,500,000. Payments began in July 2013.
2. The estimated contract cost for the new four-year contract is \$8,000,000.
3. Assume the contractor will be hired in June 2014, and payments will begin August 2014.

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
	<b>\$1,500,000</b>	<b>\$750,000</b>	<b>\$750,000</b>
 <b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
	<b>\$1,959,000</b>	<b>\$979,500</b>	<b>\$979,500</b>

**Funding:**

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

**FAMILY PACT PROGRAM ADMIN.**

OTHER ADMIN. POLICY CHANGE NUMBER: 32  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Randolph Alarcio  
 FISCAL REFERENCE NUMBER: 1675

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$1,207,000	\$1,207,000
STATE FUNDS	\$603,500	\$603,500
FEDERAL FUNDS	\$603,500	\$603,500

**DESCRIPTION****Purpose:**

This policy change estimates the cost for provider recruitment, education, and support for the Family Planning, Access, Care, and Treatment (Family PACT) program.

**Authority:**

AB 1464 (Chapter 21, Statutes of 2012)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Family PACT program has two main objectives. One is to increase access to services for low-income women and men, including adolescents. The other is to increase the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach,
- Provider enrollment, recruitment, and training,
- Training and technical assistance for medical and non-medical staff,
- Education and counseling services,
- Preventive clinical services,
- Sexually transmitted infection/HIV training and technical assistance services, and
- Toll-free referral number.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. The administrative costs for the Family PACT program are estimated in the table below:

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2013-14	\$1,207,000	\$603,500	\$603,500
FY 2014-15	\$1,207,000	\$603,500	\$603,500

**FAMILY PACT PROGRAM ADMIN.**

**OTHER ADMIN. POLICY CHANGE NUMBER: 32**

**Funding:**

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

## BUSINESS RULES EXTRACTION

OTHER ADMIN. POLICY CHANGE NUMBER: 33  
 IMPLEMENTATION DATE: 3/2014  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1814

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$1,100,000	\$1,900,000
STATE FUNDS	\$550,000	\$950,000
FEDERAL FUNDS	\$550,000	\$950,000

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of procuring a Business Rules Extraction suite of tools and services, through the General Services Software License Program, for use in the creation and maintenance of a modernized automated comprehensive procurement library.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department included the Business Rule Extraction (BRE) enhancement in the 2011 request for proposal (RFP) for the California Dental Medicaid Management Information System. The contract was subsequently awarded but it was not approved by CMS. The Department plans to procure a new dental MMIS contract that meets CMS's requirements.

In order to provide an equal advantage to all participating bidders, the Department plans to purchase a Business Rules Extraction suite of tools and services for use in the creation and maintenance of a modernized automated comprehensive procurement library. Bidders will gain a better understanding of the functionality and complexity of the legacy system CD-MMIS enabling them to complete an informed, more competitive bid.

This modernized procurement library will provide the following:

- Full disclosure of graphic and logical views of the applications/programs.
- Update business rules periodically, allowing viewing of the latest versions of process diagrams, source code flow charts, and source code details.
- Ability to electronically store documentation.
- Utilize extracted business rules to support future system enhancements, replacement, or the migration to one enterprise-wide system.

**Reason for Change from Prior Estimate:**

This is a new policy change.

## BUSINESS RULES EXTRACTION

OTHER ADMIN. POLICY CHANGE NUMBER: 33

**Methodology:**

1. Assume the Business Rules Extraction suite of tools and services will be procured in February 2014 and the services will be completed by February 2015.
2. Total estimated costs are \$3.0 million.
3. Payments will be payable in installments over a 12 month period, beginning with the Department approved start date of this project. The first payment is expected to be made in March 2014.
4. Premier Support invoices from the Software License Program Reseller will be payable on a monthly basis, based on actual hours worked.

	<b>TF</b>	<b>GF</b>	<b>FFP</b>
<b>FY 2013-14</b>	<b>\$ 1,100,000</b>	\$ 550,000	\$ 550,000
<b>FY 2014-15</b>	<b>\$ 1,900,000</b>	\$ 950,000	\$ 950,000

**Funding:**

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

## MEDS INTERFACE WITH CALHEERS

OTHER ADMIN. POLICY CHANGE NUMBER: 34  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1678

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$1,008,000	\$477,000
STATE FUNDS	\$852,800	\$410,900
FEDERAL FUNDS	\$155,200	\$66,100

### DESCRIPTION

**Purpose:**

This policy change estimates the cost for a consultant and staff to integrate the Medi-Cal Eligibility Data System (MEDS) into the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS).

**Authority:**

Affordable Care Act of 2010

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CalHEERS will be programmed to provide Modified Adjusted Gross Income eligibility determinations for individuals seeking coverage through the Health Benefit Exchange (HBEX), Medi-Cal, and the Healthy Families (HF) program. In order to provide seamless integration with the new CalHEERS system, the Department will establish and design the implementation of technology solutions for ongoing maintenance of MEDS changes and integration with CalHEERS.

The Department will receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related system changes needed to interface with the CalHEERS.

The Department is hiring eight contractors to:

- Ensure that MEDS will directly interoperate with CalHEERS,
- Modify the MEDS system to meet technical and business requirements, and
- Enhance or replace existing interfaces to be customized to become real time.

Medi-Cal's associated cost for the one-time CalHEERS development and implementation is 18%; 17% is 10/90 FFP and 1% is 35/65 FFP. CalHEERS ongoing maintenance cost is 18%; 17% is 25/75 FFP and 1% is 35/65 FFP.

CalHEERS' costs are shared between HBEX (82%) and Medi-Cal (18%). HBEX will reimburse the Department for their share.

**Reason for Change from Prior Estimate:**

There is no change.

**MEDS INTERFACE WITH CALHEERS**

OTHER ADMIN. POLICY CHANGE NUMBER: 34

**Methodology:**

1. Assume the consultants will begin development and implementation (D&I) work November 2012. Assume the consultants will begin ongoing maintenance (O&M) January 2014.
2. One-time development and implementation payments are estimated to be made monthly, beginning in December 2012. Payments will be made one month in arrears.
3. Ongoing maintenance payments are estimated to be made monthly, beginning in February 2014. Payments will be made one month in arrears.

**FY 2013-14**

<b>Title XIX</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>Reimbursement</b>
D&I	\$803,000	\$14,000	\$123,000	\$666,000
O&M*	\$194,000	\$8,000	\$25,000	\$161,000
<b>Total</b>	<b>\$997,000</b>	<b>\$22,000</b>	<b>\$148,000</b>	<b>\$827,000</b>

<b>Title XXI</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>Reimbursement</b>
D&I	\$9,000	\$3,000	\$6,000	\$0
O&M*	\$2,000	\$1,000	\$1,000	\$0
<b>Total</b>	<b>\$11,000</b>	<b>\$4,000</b>	<b>\$7,000</b>	<b>\$0</b>

**FY 2014-15**

<b>Title XIX</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>Reimbursement</b>
D&I	\$81,000	\$1,000	\$13,000	\$67,000
O&M*	\$391,000	\$17,000	\$50,000	\$324,000
<b>Total</b>	<b>\$472,000</b>	<b>\$18,000</b>	<b>\$63,000</b>	<b>\$391,000</b>

<b>Title XXI</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>Reimbursement</b>
D&I	\$1,000	\$0	\$1,000	\$0
O&M*	\$4,000	\$1,000	\$3,000	\$0
<b>Total</b>	<b>\$5,000</b>	<b>\$1,000</b>	<b>\$4,000</b>	<b>\$0</b>

	<b>TF</b>	<b>GF</b>	<b>FF</b>	<b>Reimbursement</b>
<b>FY 2013-14</b>	<b>\$1,008,000</b>	<b>\$26,000</b>	<b>\$155,000</b>	<b>\$827,000</b>
<b>FY 2014-15</b>	<b>\$477,000</b>	<b>\$19,000</b>	<b>\$67,000</b>	<b>\$391,000</b>

**Funding:**

90% Title XIX / 10 % GF (4260-101-0001/0890)

75% Title XIX / 25 % GF (4260-101-0001/0890)\*

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

## MITA

**OTHER ADMIN. POLICY CHANGE NUMBER:** 35  
**IMPLEMENTATION DATE:** 1/2011  
**ANALYST:** Sandra Bannerman  
**FISCAL REFERENCE NUMBER:** 1137

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$1,000,000	\$481,000
STATE FUNDS	\$100,000	\$48,100
FEDERAL FUNDS	\$900,000	\$432,900

### DESCRIPTION

**Purpose:**

This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Centers for Medicare and Medicaid Services (CMS) is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department will develop the ability to streamline the process to access information from various systems, which will result in cost effectiveness. CMS will not approve Advanced Planning Documents (APDs) or provide federal funding to the Department without adherence to MITA.

The MITA information architecture includes three components; Conceptual Data Model (CDM), Logical Data Model (LDM) and data standards. The Department will build an enterprise CDM and LDM as well as incorporate national data standards into its information technology systems. The Department will also perform business process re-engineering around MITA defined business processes. The Department recently completed its CMS required MITA State Self-Assessment (SS-A), which included a State MITA roadmap. The Department is expecting to complete work by April 30, 2015.

**Reason for Change from Prior Estimate:**

FY 2013-14 includes the MITA SS-A update.

**Methodology:**

- The following are the projected costs for the next update.

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
	<b>\$1,000,000</b>	<b>\$100,000</b>	<b>\$900,000</b>
 <b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
	<b>\$481,000</b>	<b>\$48,000</b>	<b>\$433,000</b>

## MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 35

**Funding:**

90% Title XIX / 10% GF (4260-101-0001/0890)

## SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

**OTHER ADMIN. POLICY CHANGE NUMBER:** 36  
**IMPLEMENTATION DATE:** 7/2002  
**ANALYST:** Candace Epstein  
**FISCAL REFERENCE NUMBER:** 258

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$950,000	\$950,000
STATE FUNDS	\$950,000	\$950,000
FEDERAL FUNDS	\$0	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of the contract with the County of San Diego for administrative services.

**Authority:**

Welfare & Institutions Code, sections 14089(g) and 14089.05

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department contracts with the County of San Diego to provide administrative services for the San Diego Geographic Managed Care program. The Department reimburses the County for staff, postage, printing, data center access, travel, health care options presentations to explain the enrollment and disenrollment process, customer assistance and problem resolution. Effective August 2003, these services are no longer eligible for federal match. The contract term is July 1, 2007 through June 30, 2014. The Department anticipates extending the contract.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. Based on contract provisions, the administrative activities costs will be \$950,000 for FY 2013-14 and FY 2014-15.

**Funding:**

100% State GF (4260-101-0001)

## MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 37  
 IMPLEMENTATION DATE: 7/2009  
 ANALYST: Cang Ly  
 FISCAL REFERENCE NUMBER: 266

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$856,000	\$856,000
STATE FUNDS	\$428,000	\$428,000
FEDERAL FUNDS	\$428,000	\$428,000

### DESCRIPTION

**Purpose:**

This policy change estimates the administrative costs of contracting for annual independent audits of the Disproportionate Share Hospital (DSH) program.

**Authority:**

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)  
 Title 42, Code of Federal Regulations, section 455.300 et. seq.

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals (approximately 150+ hospitals) have reduced their uncompensated care costs to reflect the total amount of claimed expenditures.
2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

The audits will be funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. Each fiscal year, all auditing activity will cost \$856,000 (\$428,000 GF).
2. In FY 2013-14, the Department will make final payments for the FY 2009-10 audit and partial payment for the FY 2010-11 audit.
3. In FY 2014-15, the Department will make final payment for the FY 2010-11 audit and partial payment for the FY 2011-12 audit.

**MMA - DSH ANNUAL INDEPENDENT AUDIT**

OTHER ADMIN. POLICY CHANGE NUMBER: 37

	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2013-14	\$856,000	\$428,000	\$428,000
FY 2014-15	\$856,000	\$428,000	\$428,000

**Funding:**

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

## ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 38  
 IMPLEMENTATION DATE: 5/2010  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1452

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$750,000	\$750,000
STATE FUNDS	\$375,000	\$375,000
FEDERAL FUNDS	\$375,000	\$375,000

### DESCRIPTION

**Purpose:**

This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining electronic Protected Health Information (PHI).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department plans to acquire hardware, supplies, associated maintenance and support services that are necessary to eliminate backup tapes that store electronic data. The data on these tapes contain Medi-Cal beneficiary information that is considered confidential and/or PHI by federal and state mandates. The encryption of these tapes will secure and protect Department information assets from unauthorized disclosure; protect the privacy of Medi-Cal beneficiaries; prevent lawsuits from citizens for privacy violations; avoid costs to notify millions of people if a large breach does occur; and maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

The Department is continuing its effort in upgrading the backup and recovery methods for the current infrastructure by moving from tape backup to the Disk to Disk solution. The upgrade is necessary to take advantage of technologies such as backup to disk, data de-duplication, offsite data replication, and data encryption. The maintenance and increasing amount of data involved with the migration of the Department with these technologies allows the Department to continue to grow and support its virtualization infrastructure and to provide backup and recovery methods for this infrastructure.

The upgrade allows the Department to:

- Effectively and efficiently manage Department growth,
- Provide backup and recovery methods for the business programs, and
- Ensure the data is secure and managed.

**Reason for Change from Prior Estimate:**

There is no change.

## ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 38

**Methodology:**

1. The following amounts are based upon the latest projections of cost.

<b>FY 2013-14:</b>	<u>TF</u> \$750,000	<u>GF</u> \$375,000	<u>FF</u> \$375,000
<b>FY 2014-15:</b>	<u>TF</u> \$750,000	<u>GF</u> \$375,000	<u>FF</u> \$375,000

**Funding:**

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

## MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 39  
 IMPLEMENTATION DATE: 3/2011  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1665

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$560,000	\$560,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$560,000	\$560,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR) for administrative costs related to the Inmate Eligibility Program.

**Authority:**

AB 1628 (Chapter 729, Statutes of 2010)  
 Interagency Agreement #10-87275

**Interdependent Policy Changes:**

Not Applicable

**Background:**

AB 1628 authorizes the Department and CDCR to claim federal reimbursement for inpatient hospital services for adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties. As part of these provisions, CDCR is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program.

The federal funds provided to CDCR for the cost of inpatient services for inmates deemed eligible for Medi-Cal or the Low Income Health Program are included in the Medi-Cal Inpatient Hosp. Costs for Inmates and BTR – LIHP Inpatient Hosp. Costs for CDCR Inmates policy changes respectively.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. Implementation of the Inmate Eligibility Program began April 1, 2011.
2. Reimbursements for CDCR's administrative costs began in March 2011.
3. The federal share of ongoing administrative costs is \$560,000 annually.

**Funding:**

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

## MEDS MODERNIZATION PROJECT CONTRACTORS

OTHER ADMIN. POLICY CHANGE NUMBER: 40  
 IMPLEMENTATION DATE: 7/2013  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1731

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$546,000	\$4,533,000
STATE FUNDS	\$54,600	\$453,300
FEDERAL FUNDS	\$491,400	\$4,079,700

### DESCRIPTION

**Purpose:**

This policy change estimates the cost to hire contractors to conduct a feasibility study, develop an Advance Planning Document (APD), and participate in the project planning efforts.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department is seeking to transition MEDS from a stand-alone legacy system to a modernized, integrated solution that addresses the requirements of the federal Affordable Care Act, and increases the Department's alignment with the federal Medicaid Information Technology Architecture.

In FY 2012-13, a contractor team conducted a feasibility study and developed a Feasibility Study Report (FSR)/APD. In FY 2013-14, the FSR/APD contractor will continue to participate in the project planning efforts.

The Department anticipates that the MEDS Modernization Project will begin with Business Rules Extraction (BRE) activities in January 2014, project planning activities in July 2014, and system implementation in June 2020. Beginning in FY 2014-15, additional contractors will be hired to provide technical consulting, Independent Verification and Validation (IV&V) and Independent Project Oversight (IPO). BRE activities are expected to be completed in FY 2014-15.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. For the FSR/APD contractor, the FY 2013-14 costs are based on payments through December 2013.
2. BRE consulting costs are estimated to be \$425,000 in FY 2013-14.
3. The FY 2014-15 costs are based on estimated costs for payments to the technical consulting, IV&V, IPO, and BRE contractors contained in the project's FSR/APD.
4. Payments to the BRE contractor are anticipated to begin in February 2014, while payments to

**MEDS MODERNIZATION PROJECT CONTRACTORS**

OTHER ADMIN. POLICY CHANGE NUMBER: 40

the technical consulting, IV&V, and IPO contractors are anticipated to begin in August 2014.

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
FSR/APD	\$121,000	\$12,000	\$109,000
Business Rules Extraction	\$425,000	\$42,000	\$383,000
<b>Total</b>	<b>\$546,000</b>	<b>\$54,000</b>	<b>\$492,000</b>
<b>FY 2014-15:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Project Planning	\$1,000,000	\$100,000	\$900,000
Technical Consulting Services	\$1,250,000	\$125,000	\$1,125,000
Independent Validation & Verification	\$172,000	\$17,000	\$155,000
Independent Project Oversight	\$143,000	\$14,000	\$129,000
Business Rules Extraction	\$1,968,000	\$197,000	\$1,771,000
<b>Total</b>	<b>\$4,533,000</b>	<b>\$453,000</b>	<b>\$4,080,000</b>

**Funding:**

90% Title XIX / 10% GF (4260-101-0001/0890)

**POSTAGE AND PRINTING - THIRD PARTY LIAB.**

OTHER ADMIN. POLICY CHANGE NUMBER: 41  
 IMPLEMENTATION DATE: 7/1996  
 ANALYST: Raman Pabla  
 FISCAL REFERENCE NUMBER: 240

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$539,000	\$567,000
STATE FUNDS	\$269,500	\$283,500
FEDERAL FUNDS	\$269,500	\$283,500

**DESCRIPTION****Purpose:**

This policy changes estimates the Third Party Liability postage and printing costs.

**Authority:**

Government Code 7295.4  
 AB 155 (Chapter 820 Statutes of 1999)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department uses direct mails and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms printed and mailed, as well as the number of reports received, correlates to the Medi-Cal caseload.

All forms related to Medicare Operations are available online. The Department purchased a document folder/insertion machine in FY 2012-13 to automate the mailings done in-house.

**Reason for Change from Prior Estimate:**

Streamlining efforts have reduced mailing costs.

**Methodology:**

1. The cost breakdown is shown below:

	<u>FY 2013-14</u>	<u>Postage</u>	<u>Printing</u>	<u>Total</u>
Personal Injury	\$195,000	\$31,000	\$226,000	\$226,000
Estate Recovery	\$90,000	\$203,000	\$293,000	\$293,000
Overpayments	\$4,000	\$1,000	\$5,000	\$5,000
Cost Avoidance	\$5,000	\$1,000	\$6,000	\$6,000
*AB 155 Invoices	\$7,000	\$0	\$7,000	\$7,000
**Document Folder Insertion	\$0	\$0	\$2,000	\$2,000
<b>Total</b>	<b>\$301,000</b>	<b>\$236,000</b>	<b>\$539,000</b>	<b>\$539,000</b>

**POSTAGE AND PRINTING - THIRD PARTY LIAB.**

OTHER ADMIN. POLICY CHANGE NUMBER: 41

<b>FY 2014-15</b>	<b>Postage</b>	<b>Printing</b>	<b>Total</b>
Personal Injury	\$205,000	\$33,000	\$238,000
Estate Recovery	\$95,000	\$213,000	\$308,000
Overpayments	\$5,000	\$1,000	\$6,000
Cost Avoidance	\$5,000	\$1,000	\$6,000
*AB 155 Invoices	\$7,000	\$0	\$7,000
**Document Folder Inserter	\$0	\$0	\$2,000
<b>Total</b>	<b>\$317,000</b>	<b>\$248,000</b>	<b>\$567,000</b>

\*AB 155 requires invoicing for premiums for the 250% Working Disabled Program.

\*\* Cost of maintenance agreement for the Document Folder Inserter used to process mailings in-house.

2. The estimated postage and printing costs are:

	<b>TF</b>	<b>GF</b>	<b>FFP</b>
<b>FY 2012-13:</b>	<b>\$539,000</b>	<b>\$269,500</b>	<b>\$269,500</b>
<b>FY 2013-14:</b>	<b>\$567,000</b>	<b>\$283,500</b>	<b>\$283,500</b>

**Funding:**

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

## VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 42  
 IMPLEMENTATION DATE: 12/2013  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1774

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$508,000	\$836,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$508,000	\$836,000

### DESCRIPTION

**Purpose:**

This policy change estimates the payments to the California Department of Public Health (CDPH) to improve delivery of Vital Records data.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

California birth, death, fetal death, still birth, marriage and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA—a Centers for Medicare and Medicaid Services (CMS) initiative—fosters an integrated business and information technology (IT) transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department is requesting enhanced Federal Financial Participation (FFP) to establish automated and timely processes to receive vital record data from CDPH.

**Reason for Change from Prior Estimate:**

The start date changed from July 2013 to December 2013 with first records being exchanged in January 2014.

**Methodology:**

1. Assume the Department and CDPH will receive MITA 90% FFP for Design, Development, and Installation activities and 75% FFP for ongoing costs to deliver data in an automated fashion.
2. Assume CDPH will provide the match for FFP from the Health Statistics Special Fund (HSSF).
3. Assume that establishing an automated data interchange will cost \$100,000 with 90% FFP.
4. Assume a data flow based on a monthly average of 20,000 death records and 45,000 birth records.

## VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 42

5. Assume that ongoing cost for each record will be \$1.43 to reimburse the cost associated with preparing the record for transfer and transferring the record to the Department.

\$1.43 per record x (20,000 death records + 45,000 birth records) x 12 months = \$1,115,000

<b>FY 2013-2014</b>	<b>HSSF</b>	<b>FFP</b>	<b>Total</b>
Data Interchange Development	\$10,000	\$90,000	\$100,000
Data Provision	<u>\$139,000</u>	<u>\$418,000</u>	<u>\$558,000</u>
<b>Total</b>	<b>\$149,000</b>	<b>\$508,000</b>	<b>\$658,000</b>
<b>FY 2014-2015</b>	<b>HSSF</b>	<b>FFP</b>	<b>Total</b>
Data Provision	<u>\$279,000</u>	<u>\$836,000</u>	<u>\$1,115,000</u>
<b>Total</b>	<b>\$279,000</b>	<b>\$836,000</b>	<b>\$1,115,000</b>

**Funding:**

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

## CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 44  
 IMPLEMENTATION DATE: 4/2011  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 1556

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$485,000	\$242,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$485,000	\$242,000

### DESCRIPTION

**Purpose:**

This policy change budgets the federal funding to cover administrative costs for increasing the California Community Transitions (CCT) enrollment.

**Authority:**

Money Follows the Person Rebalancing Demonstration (42 USC 1396a)  
 Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071  
 Affordable Care Act (ACA) (P.L. 111-148), Section 2403

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Pursuant to the ACA, on September 3, 2010 the Centers for Medicare and Medicaid Services (CMS) awarded the Department \$750,000 in Money Follows the Person (MFP) Rebalancing Demonstration supplemental grant funding. The Department allocated grant funding to implement an assessment tool to improve the ability of Skilled Nursing Facilities/Nursing Facilities, states, and other qualified entities to identify individuals who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase CCT enrollment. This supplemental grant funding does not require matching funds. The costs will be 100% federally funded.

CMS granted the Department an extension of this grant through September 2014 in order to complete the objectives set forth in the grant.

**Reason for Change from Prior Estimate:**

The estimated costs decreased due to the grant extension, allowing the Department to spread the costs into FY 2014-15.

**Methodology:**

1. Costs began in April 2011 totaling approximately \$11,000 Federal Financial Participation (FFP) during FY 2010-11. In FY 2012-13, additional FFP totaling approximately \$11,000 was paid.
2. Assume \$485,000 FFP will be paid in FY 2013-14, with the remaining \$242,000 FFP being paid in FY 2014-15.

## CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 44

3. Estimated costs are based on proposed expenditures for the following activities:

- Minimum Data Set (MDS) 3.0 Section Q options referrals systems,
- ADRC planning and start-up implementation,
- ADRC/MFP collaborative strategic planning,
- MDS 3.0 Section Q referrals policy development, and
- MDS/Options counseling training sessions.

**Funding:**

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

## ETL DATA SOLUTION

**OTHER ADMIN. POLICY CHANGE NUMBER:** 45  
**IMPLEMENTATION DATE:** 9/2013  
**ANALYST:** Sandra Bannerman  
**FISCAL REFERENCE NUMBER:** 1768

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$469,000	\$0
STATE FUNDS	\$77,900	\$0
FEDERAL FUNDS	\$391,100	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the cost for 1) a contractor, 2) design, development and implementation (DD&I), and 3) ongoing maintenance and operations (M&O) of the Extract, Transform and Load (ETL) data solution.

**Authority:**

Required by the Centers for Medicare and Medicaid Services (CMS) to implement the Affordable Care Act (ACA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

CMS requests data in a standardized format from the states, which allows streamlining the review of system projects related to the ACA. The Department plans to implement an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS's Transformed Statistical Information System. The project provides modern capabilities to improve business processes; by collecting comprehensive data regarding cost, quantity and quality of health care provided for Medi-Cal beneficiaries.

The Department procured a contractor to provide technical support for DD&I and M&O of the ETL data solution.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. Assume the contractor will begin DD&I work in August 2013, and payments will be made monthly beginning in September 2013.
2. Assume the DD&I contract duration will be for nine months.
3. Assume M&O costs will begin in September 2013.
4. Assume M&O contract will end in May 2014, and final payment will be made in June 2014.

**ETL DATA SOLUTION**

OTHER ADMIN. POLICY CHANGE NUMBER: 45

<b>FY 2013-14:</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
DD&I (90% FF / 10% GF)	\$289,000	\$29,000	\$260,000
<b>M&amp;O</b>			
Software (75% FF / 25% GF)	\$164,000	\$41,000	\$123,000
Hardware (50% FF / 50% GF)	\$16,000	\$8,000	\$8,000
<b>Total FY 2013-14</b>	<b>\$469,000</b>	<b>\$78,000</b>	<b>\$391,000</b>

**Funding:**

90% Title XIX / 10% GF (4260-101-0001/0890)

75% Title XIX / 25% GF (4260-101-0001/0890)

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

## MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 46  
 IMPLEMENTATION DATE: 10/2012  
 ANALYST: Raman Pabla  
 FISCAL REFERENCE NUMBER: 1590

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$400,000	\$240,000
STATE FUNDS	\$200,000	\$120,000
FEDERAL FUNDS	\$200,000	\$120,000

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of a contract with the University of Massachusetts (UMASS) to identify potential overpayments to Centers for Medicare and Medicaid Services (CMS) or Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles.

**Authority:**

Welfare & Institutions Code 14124.92  
 Contract 10-87134 A01

**Interdependent Policy Changes:**

PC 200 Medicare Buy-In Quality Review Project

**Background:**

The Department entered into a three-year contract with UMASS on October 1, 2010. UMASS assists 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 payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers. These payments are 10% of the amounts recovered.

The savings to the Department due to the amounts recovered are budgeted in the Medicare Buy-In Quality Review Project policy change.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. The cost of the contractor is 10% of the amount recovered.
2. For FY 2014-15, the case projections from UMASS assume fewer cases will be discovered for recovery.
3. Assume the annual amount recovered will be \$4,000,000 for FY 2013-14 and \$2,400,000 for FY 2014-15.

**MEDICARE BUY-IN QUALITY REVIEW PROJECT**

OTHER ADMIN. POLICY CHANGE NUMBER: 46

4. Assumed the cost of the contractor will be \$400,000 in FY 2013-14 and \$240,000 in FY 2014-15.

$\$4,000,000 \times 10\% = \$400,000$  annual contractor cost for FY 2013-14

$\$2,400,000 \times 10\% = \$240,000$  annual contractor cost for FY 2014-15

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2012-13	\$400,000	\$ 200,000	\$200,000
FY 2013-14	\$240,000	\$ 120,000	\$120,000

**Funding:**

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

## MIS/DSS CONTRACT REPROCUREMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 47  
 IMPLEMENTATION DATE: 2/2013  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1615

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$350,000	\$0
STATE FUNDS	\$87,500	\$0
FEDERAL FUNDS	\$262,500	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the cost related to hiring a contractor to assess the services to be included in the Management Information System and Decision Support System (MIS/DSS) contract.

**Authority:**

State Administrative Manual 4821  
 Title 45, Code of Federal Regulations 95.611

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The contract for ongoing development, maintenance, and operation of the MIS/DSS is scheduled to end on February 14, 2014. The Department hired a vendor to provide assistance with the reassessment of the scope of services to be included in the reprocurement of the MIS/DSS contract. The contractor began work on January 14, 2013. Resources are needed to develop the required project approval documents to achieve required state and federal level approvals and assist in conducting the reprocurement project.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

- The estimated costs for FY 2013-14 are:

	TF	GF	FF
FY 2013-14:	\$350,000	\$87,500	\$262,500

**Funding:**

75% Title XIX / 25% GF (4260-101-0001/0890)

## DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER: 48  
 IMPLEMENTATION DATE: 6/2013  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1739

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$240,000	\$239,000
STATE FUNDS	\$120,000	\$119,500
FEDERAL FUNDS	\$120,000	\$119,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of a Certified Project Manager (CPM) assisting in the development of a Planning Advanced Planning Document (PAPD).

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Centers for Medicare & Medicaid Services (CMS) determined the new dental Fiscal Intermediary (FI) contract no longer meets the regulatory criteria and conditions as a Medicaid Management Information System (MMIS) acquisition. Therefore, the contract is not eligible for enhanced federal funding. The Department has procured a CPM. The CPM will work closely with the Medi-Cal Dental Services Division (MDSD) program management and staff, CMS, and key stakeholders. The Department and CPM will develop a PAPD to ensure the CD-MMIS is in compliance with federal regulations and eligible for enhanced federal funding.

The CPM consultant is responsible for performing the full range of project management functions for the duration of this project including:

- Resource planning,
- Contract development and management,
- Risk management,
- Project reporting,
- Fiscal monitoring and reporting,
- Issue management,
- Performing a marketplace analysis of the vendor community and identify procurement alternatives and recommendations for the procurement of a new dental FI contract,
- Developing a complete and thorough PAPD that meets the regulatory criteria and conditions as a MMIS and to ensure the PAPD is developed timely and approval by CMS is obtained,
- Assisting Department staff in responding to CMS inquiries and provide additional documentation if required, and
- Developing a Request for Offer for the Department to procure Independent Verification and Validation contractor resources that will be under the direction of MDSD management.

**DENTAL PAPD PROJECT MANAGER**

OTHER ADMIN. POLICY CHANGE NUMBER: 48

**Reason for Change from Prior Estimate:**

Total estimated costs are \$498,000 instead of \$576,000. The project manager was hired in June 2013 instead of April 2013.

**Methodology:**

1. The project manager was hired in June 2013 and the contract will end April 2015.
2. Total estimated costs are \$498,000.
3. Payments began in June 2013.

	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2013-14:</b>	<b>\$240,000</b>	<b>\$120,000</b>	<b>\$120,000</b>
<b>FY 2014-15:</b>	<b>\$239,000</b>	<b>\$119,500</b>	<b>\$119,500</b>

**Funding:**

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

## PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 49  
 IMPLEMENTATION DATE: 7/2010  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1335

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$214,000	\$0
STATE FUNDS	\$107,000	\$0
FEDERAL FUNDS	\$107,000	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the costs associated with an evaluation of the Pediatric Palliative Care Waiver Pilot Project.

**Authority:**

AB 1745 (Chapter 330, 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.

AB 1745 mandated the Department to evaluate the pilot project through an independent evaluator to meet federal assurances. The independent evaluation is in progress with final data collection on October 1, 2013.

**Reason for Change from Prior Estimate:**

Amounts increased due to a contract amendment shifting cost and work into FY 2013-14.

**Methodology:**

The payments to the evaluator are scheduled to continue monthly until June 30, 2014.

**Funding:**

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

## ANNUAL EDP AUDIT CONTRACTOR

OTHER ADMIN. POLICY CHANGE NUMBER: 50  
 IMPLEMENTATION DATE: 8/2013  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 1734

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$162,000	\$162,000
STATE FUNDS	\$81,000	\$81,000
FEDERAL FUNDS	\$81,000	\$81,000

### DESCRIPTION

**Purpose:**

This policy change estimates the cost related to procuring an annual Electronic Data Processing (EDP) auditor of the Medi-Cal fiscal intermediary.

**Authority:**

Title 42, Code of Federal Regulations 95.621  
 Contract 09-86210

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Title 42, Code of Federal Regulations 95.621 requires the Department to conduct periodic onsite surveys and reviews of EDP methods and practices. The survey determines the adequacy of EDP methods and practices. Federal regulations require the Department to develop a schedule between the Department and State or local agencies prior to conducting such surveys or reviews. In addition, the Medi-Cal Fiscal Intermediary contract requires the Department to procure an audit contractor to perform an annual EDP audit. The Department currently provides this annual audit to the Bureau of State Audits to incorporate into the Single State Federal Compliance Audit for the Medicaid program.

**Reason for Changes from Prior Estimate:**

The contract costs are based on actual amounts stated in the contract executed on August 1, 2013.

**Methodology:**

1. The estimate is based on actual bid amounts.

	TF	GF	FF
FY 2013-14:	\$162,000	\$81,000	\$81,000
	TF	GF	FF
FY 2014-15:	\$162,000	\$81,000	\$81,000

**Funding:**

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

## EPOCRATES

OTHER ADMIN. POLICY CHANGE NUMBER: 51  
 IMPLEMENTATION DATE: 4/2007  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1157

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$107,000	\$107,000
STATE FUNDS	\$53,500	\$53,500
FEDERAL FUNDS	\$53,500	\$53,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of a contract with Epocrates Rx™.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Epocrates Rx™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country.

The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) and up to three other departmental "formularies", for example, Family PACT or AIDS Drug Assistance Program (ADAP), in the Epocrates system for access by subscribers.

Epocrates provides the Department with an opportunity to reach a large network of health professionals via a unique point-of-care clinical reference solution for physicians and other health professionals accessible on both handheld devices and Internet based desktop computers.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. According to the contract, the annual amount paid to Epocrates for their services is \$107,000.

Fiscal Year	Expenditures
FY 2013-14	\$107,000
FY 2014-15	\$107,000
FY 2015-16	\$107,000
FY 2016-17	\$ 9,000

**Funding:**

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

## CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 52  
 IMPLEMENTATION DATE: 7/2012  
 ANALYST: Yumie Park  
 FISCAL REFERENCE NUMBER: 1388

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$100,000	\$100,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$100,000	\$100,000

### DESCRIPTION

**Purpose:**

This policy change estimates the county funds expended above the allocations on administrative activities in support of a county's California Children's Services (CCS) Medi-Cal caseload using Certified Public Expenditures (CPE).

**Authority:**

California Health & Safety Code § 123955(f)  
 Code of Federal Regulations, Title 42, 433.51

**Interdependent Policy Changes:**

Not Applicable

**Background:**

County costs for determination of CCS Medi-Cal eligibility, care coordination, utilization management and prior authorization of services are reimbursed by Medi-Cal.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

- County funds expended above the allocations on administrative activities in support of a county's CCS Medi-Cal caseload may be used as CPE to draw down Title XIX federal financial participation (FFP). It is assumed that \$100,000 will be drawn down with counties' CPE in FY 2013-14 and FY 2014-15.

	FFP
FY 2013-14	\$100,000
FY 2014-15	\$100,000

**Funding:**

Title XIX (4260-101-0890)

## TAR POSTAGE

OTHER ADMIN. POLICY CHANGE NUMBER: 53  
 IMPLEMENTATION DATE: 7/2003  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 267

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$99,000	\$99,000
STATE FUNDS	\$49,500	\$49,500
FEDERAL FUNDS	\$49,500	\$49,500

### DESCRIPTION

**Purpose:**

This policy change estimates postage costs for Medi-Cal Treatment Authorization Requests (TAR).

**Authority:**

Welfare & Institutions Code, section 14103.6

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Not Applicable

**Reason for Change from Prior Estimate:**

The costs decreased due to the completion of Community Based Adult Services (CBAS) related mailings.

**Methodology:**

1. TAR postage costs for Medi-Cal are assumed to be \$99,000 for FY 2013-14 based on FY 2012-13 expenditures, excluding CBAS mailings.
2. For FY 2014-15, the costs for TAR postage are expected to be \$99,000.

**Funding:**

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

**DMHC INTER-AGENCY AGREEMENT - ADMIN**

OTHER ADMIN. POLICY CHANGE NUMBER: 54  
 IMPLEMENTATION DATE: 9/2013  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1815

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$79,000	\$95,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$79,000	\$95,000

**DESCRIPTION****Purpose:**

This policy change estimates the cost related to entering into an inter-agency agreement (IA) with the California Department of Managed Health Care (DMHC) to assist the Department in its monitoring of dental plans.

**Authority:**

Interagency Agreement 13-90172

**Interdependent Policy Changes:**

Not Applicable

**Background:**

SB 853 (Chapter 717, Statutes of 2010) authorized the Department to enter into an inter-agency agreement with DMHC to confirm compliance with the Medi-Cal contract by conducting financial audits, dental surveys, and a review of the provider networks of the managed care plans participating in its Medi-Cal line of business.

This policy change estimates the federal reimbursement for DMHC costs to perform the above functions.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

1. The DMHC IA is effective September 2013.
2. The reimbursement of DMHC costs begins in September 2013.
3. Assume the personnel costs are \$81,000 in FY 2013-14 and \$97,000 in FY 2014-15.
4. Assume operating expenses (travel, subcontracts, and training) costs are \$77,000 in FY 2013-14 and \$92,000 in FY 2014-15.

	<u>Personnel Costs</u>	<u>Operating Expenses</u>	<u>Total Fund</u>	<u>FFP Total</u>
FY 2013-14	\$ 81,000	\$ 77,000	\$ 158,000	<b>\$ 79,000</b>
FY 2014-15	\$ 97,000	\$ 92,000	\$ 189,000	<b>\$ 95,000</b>

## DMHC INTER-AGENCY AGREEMENT - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 54

5. The FFP portion of the cost is reimbursable to DMHC per the IA.

FY 2013-14: \$ 158,000

FY 2014-15: \$ 190,000

**Funding:**

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

## KATIE A. V. DIANA BONTA SPECIAL MASTER

OTHER ADMIN. POLICY CHANGE NUMBER: 55  
 IMPLEMENTATION DATE: 7/2009  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1453

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$70,000	\$70,000
STATE FUNDS	\$35,000	\$35,000
FEDERAL FUNDS	\$35,000	\$35,000

### DESCRIPTION

**Purpose:**

This policy changes estimates the special master costs for the *Katie A. v. Diana Bontá* lawsuit settlement.

**Authority:**

*Katie A. v Diana Bontá* lawsuit settlement

**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*. The preliminary injunction required the provision of the Early and Periodic Screening, Diagnosis and Treatment 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 the 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. The court granted final approval of the proposed settlement on December 2, 2011. On October 13, 2011, the parties began a new series of Special Master meetings to develop a plan for, and begin, settlement implementation. The Department and the California Department of Social Services (CDSS) fund the Special Master. 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.

**Reason for Change from Prior Estimate:**

Special master costs are anticipated to be lower.

**Methodology:**

1. Assume the new Special Master costs are \$140,000 for FY 2013-14 and \$140,000 for FY 2014-15.
2. The Special Master costs will be split with CDSS and each department will pay 50% of the costs.

**KATIE A. V. DIANA BONTA SPECIAL MASTER**

OTHER ADMIN. POLICY CHANGE NUMBER: 55

	<u>TF</u>	<u>CDSS TF</u>	<u>DHCS TF</u>
<b>FY 2013-14</b>	\$140,000	\$70,000	\$70,000
<b>FY 2014-15</b>	\$140,000	\$70,000	\$70,000

	<u>DHCS TF</u>	<u>GF</u>	<u>FFP</u>
<b>FY 2013-14</b>	<b>\$70,000</b>	<b>\$35,000</b>	<b>\$35,000</b>
<b>FY 2014-15</b>	<b>\$70,000</b>	<b>\$35,000</b>	<b>\$35,000</b>

**Funding:**

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

## Q5i AUTOMATED DATA SYSTEM ACQUISITION

OTHER ADMIN. POLICY CHANGE NUMBER: 56  
 IMPLEMENTATION DATE: 8/2011  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 1440

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$42,000	\$39,000
STATE FUNDS	\$21,000	\$19,500
FEDERAL FUNDS	\$21,000	\$19,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost of the Q5i automated data system and the ongoing support costs.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance, and support. The Q5i system is used to support quality control efforts for the following state and federally mandated programs: Medi-Cal Eligibility Quality Control (MEQC), County Performance Standards, Payment Error Rate Measurement (PERM), and Anti-Fraud/Program Integrity. A contract is required for maintenance and system support costs.

**Reason for Change from Prior Estimate:**

There is a new Purchase Order agreement which has changed the expenditures.

**Methodology:**

1. Ongoing costs began in March 2012.
2. These estimates are provided by the vendor.

	FY 2013-14			FY 2014-15		
	TF	GF	FFP	TF	GF	FFP
Ongoing Cost	\$42,000	\$21,000	\$21,000	\$39,000	\$19,500	\$19,500

**Funding:**

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

## RECOVERY AUDIT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 57  
 IMPLEMENTATION DATE: 1/2014  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1740

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$2,000	\$14,000
STATE FUNDS	\$1,000	\$7,000
FEDERAL FUNDS	\$1,000	\$7,000

### DESCRIPTION

**Purpose:**

This policy change estimates the costs of a Recovery Audit Contractor (RAC) retained to identify savings.

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**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 and approved the contract in April 2013. This policy change budgets the recovery audit contractor costs. See the Recovery Audit Contractor Savings policy change for the identified and recovered savings.

The four provider types identified for RAC audit are Optometrists, Podiatrists, Non-Emergency Medical Transportation (NEMT) 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 (\$125,063).

**Reason for Change from Prior Estimate:**

The change is the result of the identification of the total paid claims to the four provider types in the past three years and the RAC stated anticipation of a 1% recovery.

**Methodology:**

1. Assume annual overpayment savings identified within the first year of program implementation are:

$$\text{FY 2013-14: } \$12,506,375 \times 1\% = \$125,064$$

2. The cost of identifying overpayments is 12.5% of the amount recovered. Underpayments are not anticipated for CY or BY.

$$\text{Annual costs: } \$125,064 \times 12.5\% = \$15,633$$

**RECOVERY AUDIT CONTRACTOR COSTS**

OTHER ADMIN. POLICY CHANGE NUMBER: 57

3. Cost applies to the Department only when savings are identified and recovered.
4. Assume savings will be collected beginning January 2014. Costs of this program will be phased in over a 12 month period. Until the phase in is complete, assume \$109 in monthly costs starting January 2014 and an additional \$109 each month thereafter.
5. Estimated payments based on a cash basis are:

	<u>TF</u>	<u>GF</u>	<u>FF</u>
<b>FY 2013-14</b>	<b>\$2,000</b>	<b>\$1,000</b>	<b>\$1,000</b>
<b>FY 2014-15</b>	<b>\$14,000</b>	<b>\$7,000</b>	<b>\$7,000</b>

**Funding:**

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

## DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 58  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1813

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$0	\$14,726,000
STATE FUNDS	\$0	\$4,197,000
FEDERAL FUNDS	\$0	\$10,529,000

### DESCRIPTION

**Purpose:**

This policy change estimates the administrative costs for counties who provide Drug Medi-Cal (DMC) services.

**Authority:**

State Plan Amendment #09-022 (Pending)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Counties may obtain federal reimbursement for certain costs associated with administering DMC services. Starting July 1, 2014, DMC will require counties to report and bill for their county administration expenses separate from direct services expenses. This reporting will be required on a quarterly basis and the counties will continue annual reporting of county administration expenses in the annual cost report.

Currently counties certify DMC claims, submitted for reimbursement, for direct services and county administrative services combined. For approved claims, the Department draws down federal Medicaid reimbursement funds based on the total certified expense and pays counties the federal share of the total certified expense, based on the DMC reimbursement rate. Some counties pay their contracted service providers less than the DMC reimbursement rate and retain the difference to pay for DMC county administration expenses. Counties report the county administrative expenses once in the annual cost report.

Starting FY 2014-15, the following changes will be made:

- DMC reimbursement rate-setting methodologies will exclude county administrative expenses.
- The Department will reimburse counties for DMC county administration expenses through a new invoicing process.
- The Department will implement a new process allowing counties to claim and be paid for county administrative expenses on a quarterly basis.

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

This is a new policy change.

**DRUG MEDI-CAL COUNTY ADMINISTRATION**

OTHER ADMIN. POLICY CHANGE NUMBER: 58

**Methodology:**

1. Based on the FY 2011-12 annual cost reports, the county administration costs was \$16,247,000 for Regular DMC services and \$378,000 for Perinatal DMC services.
2. The Department assumes a 10% annual increase (from FY 2011-12 to FY 2012-13, FY 2012-13 to FY 2013-14, and FY 2013-14 to FY 2014-15).

<b>Regular DMC</b>	<b>FY 2011-12 County Admin</b>	<b>Growth</b>	<b>Projected County Admin Costs for FY 2014-15</b>
Narcotic Treatment Program	\$7,809,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$8,590,000 \$9,449,000 \$10,394,000
Intensive Outpatient Treatment	\$2,368,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$2,605,000 \$2,865,000 \$3,151,000
Outpatient Drug Free Treatment	\$1,356,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$6,677,000 \$7,344,000 \$8,079,000
Residential Treatment			\$4,332,000
<b>Total for FY 2014-15 (Regular)</b>	<b>\$16,247,000</b>	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	<b>\$17,872,000 \$19,659,000 \$21,625,000</b>

<b>Perinatal DMC</b>	<b>FY 2011-12 County Admin</b>	<b>Growth</b>	<b>Projected County Admin Costs for FY 2014-15</b>
Narcotic Treatment Program	\$31,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$34,000 \$37,000 \$41,000
Intensive Outpatient Treatment	\$118,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$130,000 \$143,000 \$157,000
Residential Treatment Program	\$154,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$169,000 \$186,000 \$204,000
Outpatient Drug Free	\$76,000	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	\$84,000 \$92,000 \$101,000
<b>Total for FY 2014-15 (Perinatal)</b>	<b>\$378,000</b>	FY 2012-13 10% FY 2013-14 10% FY 2014-15 10%	<b>\$416,000 \$458,000 \$504,000</b>
<b>Total for FY 2014-15</b>			<b>\$22,129,000</b>

3. Aid codes for the Medicaid Children's Health Insurance Program (M-CHIP), for the Breast and Cervical Cancer Treatment (BCCTP) program, and for pregnancy-related services are eligible for Title XXI federal reimbursement of 65%. Minor consent costs are funded by the counties. All other Medi-Cal claims are eligible for 50% federal reimbursement.

**DRUG MEDI-CAL COUNTY ADMINISTRATION**

OTHER ADMIN. POLICY CHANGE NUMBER: 58

	<b>Estimated County Admin</b>	<b>County Funds</b>	<b>Title XIX</b>	<b>Title XXI</b>	<b>GF</b>
Regular DMC	\$21,625,000	\$7,285,000	\$10,070,000	\$205,000	\$4,065,000
Perinatal DMC	\$504,000	\$118,000	\$247,000	\$7,000	\$132,000
<b>Total FY 2014-15</b>	<b>\$22,129,000</b>	<b>\$7,403,000</b>	<b>\$10,317,000</b>	<b>\$212,000</b>	<b>\$4,197,000</b>

**Funding:**

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

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

100% General Fund (4260-101-0001)

100% General Fund (4260-113-0001)

## NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 59  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Randolph Alarcio  
 FISCAL REFERENCE NUMBER: 1824

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$0	\$4,136,000
STATE FUNDS	\$0	\$2,068,000
FEDERAL FUNDS	\$0	\$2,068,000

### DESCRIPTION

**Purpose:**

This policy change estimates the Newborn Hearing Screening Program's (NHSP) transfer of cost from the Support Contract to the Local Assistance Budget.

**Authority:**

AB 2780 (Chapter 310, Statutes of 1998)  
 Health & Safety Code Section 123975 and Sections 124115 - 124120.5

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Currently, the funding for NHSP services is budgeted in the Medi-Cal Appropriation and the contract service is budgeted in the State Support Appropriation.

The NHSP inpatient and outpatient hearing screens, the diagnostic hearing evaluations, and medical interventions is budgeted in the Local Assistance Medi-Cal Estimate.

In the December 1997 Budget Change Proposal, State Support costs were identified for the Hearing Coordination Centers (HCC) and the Data Management Service (DMS). The HCCs provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who needs follow-up to assure they receive the needed services and referrals.

The DMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The DMS provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.

Since the Support Contract is directly related to providing services to beneficiaries, the costs have been shifted to the Local Assistance Budget.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**NEWBORN HEARING SCREENING PROGRAM**

OTHER ADMIN. POLICY CHANGE NUMBER: 59

**Methodology:**

1. Currently, the HCC's contract totals \$3,043,515, the DMS contract totals \$500,000 and the Natus contract totals \$592,928. The total amount shifting from State Support to Local Assistance is \$4,136,443.

HCC contract	\$3,043,515
DMS contract	\$500,000
Natus contract	\$592,928
<b>Total</b>	<b>\$4,136,000</b>

2. Assume the shift from state Support to the Local Assistance Budget will begin in July 2014.

**Funding:**

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

## RATE STUDIES FOR MAIC AND AAC VENDOR

OTHER ADMIN. POLICY CHANGE NUMBER: 60  
 IMPLEMENTATION DATE: 7/2014  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1483

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$0	\$1,000,000
STATE FUNDS	\$0	\$500,000
FEDERAL FUNDS	\$0	\$500,000

### DESCRIPTION

**Purpose:**

This policy change estimates the cost related to hiring a contractor to survey drug price information from pharmacies.

**Authority:**

AB 102 (Chapter 29, Statutes of 2011)  
 Welfare & Institutions (W&I) Code, sections 14105.45 and 14105.451

**Interdependent Policy Changes:**

Not Applicable

**Background:**

W&I Code section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. Currently, the Department is subject to a court injunction which precludes implementation of the MAIC methodology.

AB 102 authorized the Department to develop a reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price. MAICs based on the new reimbursement benchmark, AACs, are not subject to the injunction.

To obtain information from providers necessary to establish the MAICs and AACs, the Department will hire a contractor to survey drug price information from Medi-Cal pharmacy providers and update MAICs and AACs on an ongoing basis. A project management contractor will be assigned to oversee the implementation of the AAC vendor program.

**Reason for Change from Prior Estimate:**

The implementation date changed to July 2014.

**Methodology:**

1. Assume the contractors costs will be \$1,000,000 TF (\$500,000 GF) annually, beginning July 1, 2014.

**RATE STUDIES FOR MAIC AND AAC VENDOR**

OTHER ADMIN. POLICY CHANGE NUMBER: 60

2. Estimated contractors' costs are:

	<b>FY 2014-15</b>
Project Management Contractor	\$ 270,000
MAIC/AAC Vendor Contractor	\$ 730,000
<b>Total</b>	<b>\$ 1,000,000</b>

**Funding:**

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

## PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 61  
 IMPLEMENTATION DATE: 4/1993  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 236

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$262,937,000	\$249,240,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$262,937,000	\$249,240,000

### DESCRIPTION

**Purpose:**

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP), and IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

**Authority:**

Interagency Agreement 03-75676

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The IHSS programs, PCSP and IPO, enable eligible individuals to remain safely in their own homes as an alternative to out-of-home care. The PCSP and IPO program provide benefits that include domestic services, non-medical personal care services, and supportive services. The Medi-Cal program includes PCSP in its schedule of benefits.

Both the CMIPS Legacy and CMIPS II are currently used to authorize IHSS payments and provide CDSS and the counties with information such as wages, taxes, hours per case, cost per hour, caseload, and funding ratios.

**Reason for Change from Prior Estimate:**

Updated expenditure data was provided by CDSS.

**PERSONAL CARE SERVICES**  
OTHER ADMIN. POLICY CHANGE NUMBER: 61

**Methodology:**

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

<b>FY 2013-14</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF/ County Match</b>
EW Time & Health Related	\$420,102,000	\$210,051,000	\$210,051,000
CMIPS II	\$105,771,000	\$52,886,000	\$52,886,000
<b>Total</b>	<b>\$525,873,000</b>	<b>\$262,937,000</b>	<b>\$262,937,000</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF/ County Match</b>
EW Time & Health Related	\$426,708,000	\$213,354,000	\$213,354,000
CMIPS II	\$71,772,000	\$35,886,000	\$35,886,000
<b>Total</b>	<b>\$498,480,000</b>	<b>\$249,240,000</b>	<b>\$249,240,000</b>

**Funding:**

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

## HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 62  
 IMPLEMENTATION DATE: 7/1992  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 233

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$219,207,000	\$232,467,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$219,207,000	\$232,467,000

### DESCRIPTION

**Purpose:**

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for certain health-related activities provided by county social workers.

This policy change reflects the 100% FFP provided to CDSS.

**Authority:**

Interagency Agreements:

CWS 01-15931

CWS/CMS 06-55834

CSBG/APS 01-15931

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); and 4) Adult Protective Services (APS).

**Reason for Change from Prior Estimate:**

Updated expenditure data received from CDSS.

**Methodology:**

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

	TF	DHCS FFP	CDSS GF/ County Match
FY 2013-14			
CWS	\$238,108,000	\$119,054,000	\$119,054,000
CWS/CMS	\$8,510,000	\$4,255,000	\$4,255,000
CSBG/APS	\$191,796,000	\$95,898,000	\$95,898,000
<b>TOTAL</b>	<b>\$438,414,000</b>	<b>\$219,207,000</b>	<b>\$219,207,000</b>

**HEALTH-RELATED ACTIVITIES - CDSS**

OTHER ADMIN. POLICY CHANGE NUMBER: 62

<b>FY 2014-15</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF</b>
CWS	\$249,496,000	\$130,442,000	\$130,442,000
CWS/CMS	\$10,382,000	\$6,127,000	\$6,127,000
CSBG/APS	\$191,796,000	\$95,898,000	\$95,898,000
<b>TOTAL</b>	<b>\$451,674,000</b>	<b>\$232,467,000</b>	<b>\$232,467,000</b>

**Funding:**

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

## CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 63  
 IMPLEMENTATION DATE: 7/1997  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 243

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$40,187,000	\$31,196,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$40,187,000	\$31,196,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) administrative costs.

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Changes:**

Not Applicable.

**Background:**

CDDS administrative costs are comprised of Developmental Centers (DC) Medi-Cal Administration, Developmental Centers Medi-Cal Eligibility Contract, Home and Community Based Services (HCBS) Waiver Administration, Regional Centers (RC) Medicaid Administration, Regional Centers Nursing Home Reform (NHR), and Targeted Case Management (TCM).

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:**

The changes are due to updated expenditures.

**Methodology:**

1. CDDS provides the following cash estimates of its administrative cost components:

**CDDS ADMINISTRATIVE COSTS**

OTHER ADMIN. POLICY CHANGE NUMBER: 63

<b>FY 2013-14</b>	<b>DHCS FFP</b>	<b>CDDS GF</b>	<b>IA #</b>
1 DC/SOSF Medi-Cal Admin.	\$12,517,000	\$12,517,000	03-75282/83
DC/SOSF HIPAA*	\$163,000	\$0	03-75282/83
2 DC/SOSF MC Elig	\$504,000	\$504,000	01-15378
3 HCBS Waiver Admin.	\$9,979,000	\$9,979,000	01-15834
4 RC Medicaid Admin.	\$11,294,000	\$3,765,000	03-75734
5 NHR Admin.	\$142,000	\$142,000	03-75285
6 TCM HQ Admin.	\$398,000	\$398,000	03-75284
TCM RC Admin.	\$4,552,000	\$4,552,000	03-75284
TCM HIPAA*	\$638,000	\$0	03-75284
<b>Total</b>	<b>\$40,187,000</b>	<b>\$31,857,000</b>	

<b>FY 2014-15</b>	<b>DHCS FFP</b>	<b>CDDS GF</b>	<b>IA #</b>
1 DC/SOSF Medi-Cal Admin.	\$6,686,000	\$6,686,000	03-75282/83
DC/SOSF HIPAA*	\$163,000	\$0	03-75282/83
2 DC/SOSF MC Elig	\$500,000	\$500,000	01-15378
3 HCBS Waiver Admin.	\$10,322,000	\$10,322,000	01-15834
4 RC Medicaid Admin.	\$8,654,000	\$2,885,000	03-75734
5 NHR Admin.	\$175,000	\$175,000	03-75285
6 TCM HQ Admin.	\$330,000	\$330,000	03-75284
TCM RC Admin.	\$3,728,000	\$3,728,000	03-75284
TCM HIPAA*	\$638,000	\$0	03-75284
<b>Total</b>	<b>\$31,196,000</b>	<b>\$24,626,000</b>	

**Funding:**

100% Title XIX (4260-101-0890)

100% HIPAA FFP (4260-117-0890)\*

## MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 64  
 IMPLEMENTATION DATE: 7/1992  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 234

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$29,169,000	\$29,702,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$29,169,000	\$29,702,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child and Adolescent Health (MCAH) programs.

**Authority:**

Interagency agreement (IA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The MCAH includes the following programs:

- Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African-American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants.
- Comprehensive Perinatal Services Program (CPSP): Provides a wide range of services to Medi-Cal pregnant women, from conception through 60 days postpartum.
- Prenatal Care Guidance (PCG): Case management services for improved access to early obstetrical care for Medi-Cal eligible pregnant women.
- Scope of Work (SOW) Local Program Activities: Perinatal education, services, and referral provided to Medi-Cal eligible women.
- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal eligible pregnant teens including education and prevention of subsequent pregnancies.

**Reason for Change from Prior Estimate:**

The changes are due to expenditures paid in FY 2012-13 that was originally budgeted to be paid in FY 2013-14.

**Methodology:**

1. Local agencies match Title XIX federal funds with Certified Public Expenditures (CPE).
2. Annual expenditures on the accrual basis are \$24,655,000. Cash basis expenditures vary from

## MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 64

year-to-year based on when claims are actually paid.

3. The FY 2013-14 budgeted amounts include \$6,805,300 for FY 2011-12 and \$7,570,600 for FY 2012-13.
4. The FY 2014-15 budgeted amounts include \$5,047,100 for FY 2012-13 and \$9,862,000 for FY 2013-14 in remaining payments; and the estimate of \$14,793,000 for FY2014-15.
5. The following estimates have been provided on a cash basis by CDPH.

(Dollars in Thousands)

FY 2013-14	DHCS FFP	County Match	IA #
BIH	\$3,022	\$2,553	07-65592
CPSP, PCG & SOW	\$24,854	\$16,626	
AFLP	\$1,293	\$1,191	
<b>Total</b>	<b>\$29,169</b>	<b>\$20,370</b>	

(Dollars in Thousands)

FY 2014-15	DHCS FFP	County Match	IA #
BIH	\$3,368	\$2,854	07-65592
CPSP, PCG & SOW	\$24,844	\$17,167	
AFLP	\$1,490	\$1,381	
<b>Total</b>	<b>\$29,702</b>	<b>\$21,402</b>	

**Funding:**

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

## HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 65  
 IMPLEMENTATION DATE: 7/1999  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 246

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$25,143,000	\$25,143,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$25,143,000	\$25,143,000

### DESCRIPTION

**Purpose:**

This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

**Authority:**

Welfare & Institutions Code, section 16501.3  
 AB 1111 (Chapter 147, Statutes of 1999)  
 SB 1013 (Chapter 35, Statutes of 2012)  
 Interagency Agreement (IA) 10-87071

**Interdependent Policy Change:**

Not Applicable

**Background:**

The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 was signed into law on October 7, 2008 to help:

- Connect and support relative caregivers,
- Improve the outcome for children in foster care,
- Provide for tribal foster care and adoption access, and
- Improve incentives for adoption.

On January 1, 2010, the Department, collaborating with the CDSS, implemented the new requirements to provide Health Oversight and Coordination.

The Budget Act of 1999 appropriated state General Funds (GF) to CDSS for the purpose of increasing the use of public health nurses in meeting the health care needs of children in foster care. AB 1111 established the enabling legislation for the HCPCFC. CDSS and the Department subsequently agreed to implement the HCPCFC through the existing Child Health and Disability Prevention (CHDP) program so counties can employ public health nurses to help foster care children access health-related services. The Department used the GF budgeted in the CDSS and drew down FFP at the skilled professional medical staff enhanced rate of 75%. The aggregate funding passed through local CHDP programs to support the HCPCFC.

The 2011 State/Local Program Realignment Initiative (Realignment) shifted the responsibilities for California child welfare system to the counties. Vehicle License Fund and Sales Tax revenues supplant the GF as the non-federal share. Due to concerns from state, federal, and local stakeholders

## HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 65

that Realignment would effectively eliminate the HCPCFC as a cohesive and effective statewide system, SB 1013 provides continuing funding under the existing model to local CHDP programs. CDSS will redirect funds for this purpose from the newly established Local Revenue Fund of 2011. SB 1013 also requires the HCPCFC to be realigned to local control once the Department obtains the federal approval for child welfare agencies to claim FFP. CDSS anticipates that the transfer of the program to local control will occur by FY 2014-15.

### Reason for Change from Prior Estimate:

There is no change.

### Methodology:

1. CDSS provides the annual Local Revenue Fund of \$8,381,000.

(In Thousands)	<b>DHCS FFP</b>	<b>Local Revenue Fund</b>
<b>FY 2013-14</b>	<b>\$25,143</b>	<b>\$8,381</b>
<b>FY 2014-15</b>	<b>DHCS FFP</b>	<b>Local Revenue Fund</b>
	<b>\$25,143</b>	<b>\$8,381</b>

### Funding:

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

## DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 66  
 IMPLEMENTATION DATE: 7/2002  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 256

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$33,229,000	\$27,499,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$33,229,000	\$27,499,000

### DESCRIPTION

**Purpose:**

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

**Authority:**

Interagency Agreements:

IHSS PCSP	03-75676
IHSS Health Related	01-15931
CWS/CMS for Medi-Cal	06-55834
IHSS Plus Option Sec. 1915(j)	09-86307
SAWS	04-35639
Medi-Cal State Hearings	10-87031 and 12-89543
Public Inquiry and Response	10-87023
Medicaid Disability Evaluation Services	10-87027
Licensing Related Activities for Mental Health Facilities	12-89443

**Interdependent Policy Changes:**

Not Applicable

**Background:**

These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS) and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

**Reason for Change from Prior Estimate:**

The estimated costs have changed due to revised expenditure data. Additionally, CDSS is no longer seeking reimbursement for administrative costs related to the California Community Transitions – Money Follows the Persons contract.

**DEPARTMENT OF SOCIAL SERVICES ADMIN COST**

OTHER ADMIN. POLICY CHANGE NUMBER: 66

**Methodology:**

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

<b>FY 2013-14</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF</b>
IHSS PCSP	\$12,744,000	\$6,372,000	\$6,372,000
IHSS Health Related	\$66,000	\$33,000	\$33,000
CWS/CMS for Medi-Cal	\$578,000	\$289,000	\$289,000
IHSS Plus Option Sec. 1915(j)	\$6,100,000	\$3,050,000	\$3,050,000
SAWS	\$454,000	\$227,000	\$227,000
Medi-Cal State Hearings	\$19,598,000	\$9,799,000	\$9,799,000
Public Inquiry and Response	\$256,000	\$128,000	\$128,000
Medicaid Disability Evaluation Services	\$26,368,000	\$13,184,000	\$13,184,000
Licensing Related Activities for Mental Health Facilities	\$294,000	\$147,000	\$147,000
<b>TOTAL</b>	<b>\$66,458,000</b>	<b>\$33,229,000</b>	<b>\$33,229,000</b>

<b>FY 2014-15</b>	<b>TF</b>	<b>DHCS FFP</b>	<b>CDSS GF</b>
IHSS PCSP	\$10,132,000	\$5,066,000	\$5,066,000
IHSS Health Related	\$68,000	\$34,000	\$34,000
CWS/CMS for Medi-Cal	\$490,000	\$245,000	\$245,000
IHSS Plus Option Sec. 1915(j)	\$6,060,000	\$3,030,000	\$3,030,000
SAWS	\$426,000	\$213,000	\$213,000
Medi-Cal State Hearings	\$10,736,000	\$5,368,000	\$5,368,000
Public Inquiry and Response	\$614,000	\$307,000	\$307,000
Medicaid Disability Evaluation Services	\$26,472,000	\$13,236,000	\$13,236,000
Licensing Related Activities for Mental Health Facilities	\$0	\$0	\$0
	<b>\$54,998,000</b>	<b>\$27,499,000</b>	<b>\$27,499,000</b>

**Funding:**

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

## FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 67  
 IMPLEMENTATION DATE: 7/2007  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 1192

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$18,730,000	\$17,156,000
STATE FUNDS	\$2,780,000	\$2,533,000
FEDERAL FUNDS	\$15,950,000	\$14,623,000

### DESCRIPTION

**Purpose:**

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to services provided to Medi-Cal beneficiaries.

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department entered into an IA with CDPH to allow for the provision of Title XIX federal funds as a reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following programs support costs:

- Maternal, Child and Adolescent Health
- Office of AIDS
- Childhood Lead Prevention Program
- Health Information and Strategic Planning
- Licensing and Certification
- Skilled Nursing Facilities

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability payment program for nursing facilities (NF-Bs). The Department will reimburse CDPH's Skilled Nursing Facilities administrative costs from this Special Fund.

The Skilled Professional Medical Personnel cost are budgeted under the Maternal, Child and Adolescent Health program, and has an enhanced FMAP of 75%.

**Reason for Change from Prior Estimate:**

The changes are due to updated actual expenditures and enhanced FMAP of 75% for Skilled Professional Medical Personnel which is budgeted under Maternal, Child and Adolescent Health program.

**Methodology:**

1. Assume CDPH provides the General Fund match.

## FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 67

2. For Maternal, Child and Adolescent Health, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel costs.
3. CDPH provided the following estimates.

### FY 2013-14

Cash Basis	DHCS FFP*	DHCS SP**	CDPH GF	Other Match
Maternal, Child and Adolescent Health	\$2,180,000	\$0	\$1,902,000	\$0
Office of AIDS	\$277,000	\$0	\$277,000	\$0
Childhood Lead Prevention Program	\$1,415,000	\$0	\$0	\$1,415,000
Health Information and Strategic Planning	\$718,000	\$0	\$0	\$718,000
Licensing and Certification	\$8,580,000	\$0	\$0	\$8,580,000
Skilled Nursing Facilities	\$2,780,000	\$2,780,000	\$0	\$0
<b>Total</b>	<b>\$15,950,000</b>	<b>\$2,780,000</b>	<b>\$2,179,000</b>	<b>\$10,713,000</b>

### FY 2014-15

Cash Basis	DHCS FFP*	DHCS SP**	CDPH GF	Other Match
Maternal, Child and Adolescent Health	\$2,180,000	\$0	\$1,902,000	\$0
Office of AIDS	\$317,000	\$0	\$317,000	\$0
Childhood Lead Prevention Program	\$1,190,000	\$0	\$0	\$1,190,000
Health Information and Strategic Planning	\$718,000	\$0	\$0	\$718,000
Licensing and Certification	\$7,685,000	\$0	\$0	\$7,685,000
Skilled Nursing Facilities	\$2,533,000	\$2,533,000	\$0	\$0
<b>Total</b>	<b>\$14,623,000</b>	<b>\$2,533,000</b>	<b>\$2,219,000</b>	<b>\$9,593,000</b>

**FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT  
COSTS**  
OTHER ADMIN. POLICY CHANGE NUMBER: 67

**Funding:**

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

SNF Quality & Accountability (non-GF) (4260-605-3167)\*\*

## CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 68  
 IMPLEMENTATION DATE: 7/1997  
 ANALYST: Joel Singh  
 FISCAL REFERENCE NUMBER: 239

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$7,400,000	\$5,200,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$7,400,000	\$5,200,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA) #07-65689

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The CLPP Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments which provide the case management services. Some of these services are provided to Medi-Cal eligibles. To the extent that local governments provide case management services to Medi-Cal eligibles, federal matching funds can be claimed. The federal match is provided to CDPH through an IA.

**Reason for Change from Prior Estimate:**

The changes are due to delay in contract approval.

**Methodology:**

1. Annual expenditures on the accrual basis are \$8,400,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.

(In Thousands)

	<u>DHCS FFP</u>	<u>CDPH CLPP Fee Funds</u>
<b>FY 2013-14</b>		
Administrative Costs	\$7,400	\$7,400
<b>FY 2014-15</b>	<u>DHCS FFP</u>	<u>CDPH CLPP Fee Funds</u>
Administrative Costs	\$5,200	\$5,200

**Funding:**

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

## SINGLE POINT OF ENTRY - MEDI-CAL ONLY

OTHER ADMIN. POLICY CHANGE NUMBER: 69  
 IMPLEMENTATION DATE: 1/2013  
 ANALYST: Ryan Witz  
 FISCAL REFERENCE NUMBER: 1748

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$7,049,000	\$7,049,000
STATE FUNDS	\$2,784,400	\$2,784,400
FEDERAL FUNDS	\$4,264,600	\$4,264,600

### DESCRIPTION

**Purpose:**

This policy change estimates the costs for screening Single Point of Entry (SPE) and Child Health & Disability Prevention (CHDP) Gateway applications for the Medi-Cal program.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Department and Managed Risk Medical Insurance Board (MRMIB) developed an application form for the Healthy Families Program (HFP), which was also used as a screening tool for the Medi-Cal children's percent programs. Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP subscribers will transition to the Medi-Cal Program as targeted low-income children. The Department has retained MAXIMUS as the SPE and has contracted with them through June 2017. Completed applications are sent to the SPE to screen and forward to the county welfare departments (CWD) for a Medi-Cal determination for the children's percent programs or to the new targeted low-income children's program (TLICP).

The CHDP Gateway program was implemented July 1, 2003, to help ensure that all children have access to medical care. Through this program, children who receive a CHDP screen are pre-enrolled (PE) in Medi-Cal. Each PE child's family that indicates a desire for ongoing Medi-Cal coverage is sent a cover letter and an application. The application is returned to the SPE and is screened for the Medi-Cal children's percent programs and forwarded to the CWD for a Medi-Cal determination.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. This estimate is based on actual usage of the application; and actual processing, postage, and vendor contract rates and services. SPE services include: customer service representatives related to processing applications and premium related calls, telephony charges, help desk operation, call center support staff, and overnight federal express shipment of documentation to the counties.

**SINGLE POINT OF ENTRY - MEDI-CAL ONLY**

OTHER ADMIN. POLICY CHANGE NUMBER: 69

2. Telephone and pre-printed application costs are eligible for Title XIX 50/50 and Title 65/35 FMAP. Based on FY 2012-13 actuals, the average cost ratio is 30% Title XIX 50/50 and 70% Title XXI 65/35.

<b>FY 2013-14</b>	<b>GF</b>	<b>FF</b>	<b>TF</b>
Call Minute Rate per Minute	\$2,192,000	\$3,357,000	\$5,549,000
Transaction Forwarding Fee	\$592,500	\$907,500	\$1,500,000
<b>Total</b>	<b>\$2,784,500</b>	<b>\$4,264,500</b>	<b>\$7,049,000</b>

<b>FY 2014-15</b>	<b>GF</b>	<b>FF</b>	<b>TF</b>
Call Minute Rate per Minute	\$2,192,000	\$3,357,000	\$5,549,000
Transaction Forwarding Fee	\$592,500	\$907,500	\$1,500,000
<b>Total</b>	<b>\$2,784,500</b>	<b>\$4,264,500</b>	<b>\$7,049,000</b>

**Funding:**

	<b>GF</b>	<b>FF</b>	<b>TF</b>
50% Title XIX / 50% GF (4260-101-0890/0001)	\$1,057,500	\$1,057,500	\$2,115,000
65% Title XXI / 35% GF (4260-113-0890/0001)	\$1,726,900	\$3,207,100	\$4,934,000

## DEPARTMENT OF AGING ADMINISTRATIVE COSTS

**OTHER ADMIN. POLICY CHANGE NUMBER:** 70  
**IMPLEMENTATION DATE:** 7/1984  
**ANALYST:** Davonna McClendon  
**FISCAL REFERENCE NUMBER:** 253

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$3,072,000	\$3,563,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,072,000	\$3,563,000

### DESCRIPTION

**Purpose:**

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP). Enhanced federal funding is also provided to CDA for administrative costs related to services provided to eligibles utilizing Aging and Disability Resource Centers (ADRC).

**Authority:**

Interagency Agreement

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

**Reason for Change from Prior Estimate:**

Updated budget projections decreased the FY 2013-14 estimated costs.

**DEPARTMENT OF AGING ADMINISTRATIVE COSTS**

OTHER ADMIN. POLICY CHANGE NUMBER: 70

**Methodology:**

The estimates below, on a cash basis, were provided by CDA.

(Dollars in Thousands)

	FY 2013-14		FY 2014-15	
	CDA GF	FFP	CDA GF	FFP
<b>CBAS Support</b>				
FY 2012-13 DOS	\$5	\$6		
FY 2013-14 DOS	\$1,459	\$1,686	\$45	\$52
FY 2014-15 DOS			\$1,459	\$1,686
<b>Total CBAS</b>	<b>\$1,464</b>	<b>\$1,692</b>	<b>\$1,504</b>	<b>\$1,738</b>
<b>MSSP Support</b>				
FY 2012-13 DOS	\$4	\$4		
FY 2013-14 DOS	\$1,189	\$1,376	\$37	\$43
FY 2014-15 DOS			\$1,189	\$1,376
<b>Total MSSP</b>	<b>\$1,193</b>	<b>\$1,380</b>	<b>\$1,226</b>	<b>\$1,419</b>
<b>ADRC Support*</b>				
FY 2014-15 DOS			\$0	\$406
<b>Grand Total</b>	<b>\$2,657</b>	<b>\$3,072</b>	<b>\$2,730</b>	<b>\$3,563</b>

**Funding:**

100% Title XIX (4260-101-0890)

100% MFP Federal Grant (4260-106-0890)\*

## CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 71  
 IMPLEMENTATION DATE: 7/2003  
 ANALYST: Randolph Alarcio  
 FISCAL REFERENCE NUMBER: 261

	<b>FY 2013-14</b>	<b>FY 2014-15</b>
TOTAL FUNDS	\$1,375,000	\$1,237,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,375,000	\$1,237,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for the Information and Education (I&E) program to establish and implement clinical linkages to the Family Planning, Access, Care and Treatment (Family PACT) program.

**Authority:**

Interagency Agreement 07-65592  
 AB 1762 (Chapter 230, Statutes of 2003)

**Interdependent Policy Changes:**

Not Applicable

**Background:**

AB 1762 authorized the Department to require contractors and grantees under the Office of Family Planning (OFP), and the I&E Program to establish and implement clinical linkages to the Family PACT program. This linkage includes planning and development of a referral process for program participants to ensure access to family planning and other reproductive health care services, including a technical assistance, training, and evaluation component for grantees.

**Reason for Change from Prior Estimate:**

Updated FFP reimbursement amounts are based on actual data.

**Methodology:**

1. CDPH budgets the non-federal matching funds.
2. CDPH provides the estimated costs on a cash basis.

	<b>TF</b>	<b>CDPH GF</b>	<b>DHCS FF</b>
FY 2012-13	\$1,017,000	\$509,000	\$509,000
FY 2013-14	\$1,732,000	\$866,000	\$866,000
<b>Total FY 2013-14</b>	<b>\$2,749,000</b>	<b>\$1,375,000</b>	<b>\$1,375,000</b>
	<b>TF</b>	<b>CDPH GF</b>	<b>DHCS FF</b>
FY 2013-14	\$742,000	\$371,000	\$371,000
FY 2014-15	\$1,732,000	\$866,000	\$866,000
<b>Total FY 2014-15</b>	<b>\$2,474,000</b>	<b>\$1,237,000</b>	<b>\$1,237,000</b>

## CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 71

**Funding:**

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

## CDDS DENTAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 72  
 IMPLEMENTATION DATE: 11/2011  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1631

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$1,270,000	\$1,270,000
STATE FUNDS	\$1,270,000	\$1,270,000
FEDERAL FUNDS	\$0	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the cost related to processing California Department of Development Services (CDDS) dental claims.

**Authority:**

Interagency Agreement 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 interagency agreement 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 processing claims and benefits will be reimbursed by CDDS.

This policy change estimates the reimbursement of administration costs. The reimbursement of benefit costs is budgeted in the CDDS Dental Services policy change.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. An update to the CD-MMIS began in November 2011.
2. The processing of claims began in January 2012 and payments to providers began in February 2012.
3. Assume the cost of processing claims is \$1,270,000 annually.
4. All costs are reimbursed by CDDS.

**FY 2013-14: \$1,270,000**

**FY 2014-15: \$1,270,000**

## CDDS DENTAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 72

**Funding:**

Reimbursement GF (4260-610-0995)

## KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 73  
 IMPLEMENTATION DATE: 7/2001  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 249

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$1,017,000	\$1,017,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,017,000	\$1,017,000

### DESCRIPTION

**Purpose:**

This policy change estimates the federal match provided to the California Children and Families Commission (CCFC) for providing "Welcome Kits" to parents of Medi-Cal eligible newborns.

**Authority:**

Interagency Agreement (IA) #03-76097

**Interdependent Policy Changes:**

Not Applicable

**Background:**

In November 2001, CCFC and the Department entered into an IA to allow the Department to claim Title XIX federal financial participation (FFP) for the "Welcome Kits" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. CCFC will distribute an estimated 370,000 kits in FY 2013-14 and FY 2014-15, of these 46% of the kits are expected to be distributed to Medi-Cal eligible newborns.

$$370,000 \text{ kits} \times 46\% = 170,200 \text{ Medi-Cal kits}$$

2. Approximately 51% of the kits distributed will be basic kits and 49% will be custom kits.

$$170,200 \text{ Medi-Cal kits} \times 51\% = 86,802 \text{ basic kits}$$

$$170,200 \text{ Medi-Cal kits} \times 49\% = 83,398 \text{ custom kits}$$

3. As of November 1, 2010, the basic kit costs \$11.89 and the customized kit, which contains an additional item specific to the county of birth, costs \$12.01.
4. Costs of \$501,000 for FY 2012-13 will be paid in FY 2013-14 and \$501,000 for FY 2013-14 will be paid in FY 2014-15.

**KIT FOR NEW PARENTS**

OTHER ADMIN. POLICY CHANGE NUMBER: 73

**Annual Cost (Accrual Basis)**

86,802 basic kits x \$11.89	\$1,032,000
83,398 custom kits x \$12.01	<u>\$1,002,000</u>
<b>Total FY 2012-13 Cost</b>	<b>\$2,034,000</b>

<b>Cash Basis</b>	<b>FY 2013-14</b>	<b>FY 2014-15</b>
FY 2012-13	<u>\$501,000</u>	<u>\$0</u>
FY 2013-14	\$1,533,000	\$501,000
FY 2014-15	<u>\$0</u>	<u>\$1,533,000</u>
Total:	\$2,034,000	\$2,034,000
<b>FFP Total:</b>	<b>\$1,017,000</b>	<b>\$1,017,000</b>

**Funding:**

100% Title FFP (4260-101-0890)

## QUITLINE ADMINISTRATIVE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 74  
 IMPLEMENTATION DATE: 1/2014  
 ANALYST: Andrew Yoo  
 FISCAL REFERENCE NUMBER: 1680

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$1,000,000	\$2,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,000,000	\$2,000,000

### DESCRIPTION

**Purpose:**

This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to Quitline services.

**Authority:**

Interagency Agreement (IA)

**Interdependent Policy Change:**

Not Applicable

**Background:**

Quitline is the California Smokers' Helpline, operated by the University of California, San Diego. Quitline provides a free telephone-based counseling program to provide advice, education, and support to callers who currently smoke or have recently quit smoking.

Currently, Quitline receives its funding through CDPH and other sources. The IA between the Department and CDPH would enable the State to receive 50% FFP for Quitline services administration costs related to services provided to Medicaid individuals. Beginning in FY 2013-14, the Department will claim FFP and reimburse CDPH through an IA.

**Reason for Change from Prior Estimate:**

The change is due to a delay in contract approval.

**Methodology:**

1. The program's effective date is July 1, 2013.
2. Total Quitline services administration costs are \$4 million annually.
3. Assume 50% of callers are Medi-Cal beneficiaries.
4. The State receives 50% FFP. The estimated annual FFP on an accrual basis is \$1,000,000.
5. The Department expects to reimburse CDPH a total amount of \$1,000,000 in FY 2013-14 beginning January 2014.

**Funding:**

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

## VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 75  
 IMPLEMENTATION DATE: 12/1988  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 232

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$956,000	\$956,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$956,000	\$956,000

### DESCRIPTION

**Purpose:**

This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

**Authority:**

California Military & Veterans Code 972.5  
 Interagency Agreement 13-90149

**Interdependent Policy Changes:**

Not Applicable

**Background:**

County Veteran Services officers help identify additional veterans benefits and refers the veteran to utilize those services instead of Medi-Cal. This process avoids costs for the Medi-Cal program. The contract amounts for FY 2013-14 and FY 2014-15 is estimated to be \$956,000. The non-federal match is budgeted at CDVA.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

**Cash Basis**

	TF	DHCS FFP	CDVA GF
<b>FY 2013-14</b>			
Administrative	\$436,000	\$218,000	\$218,000
Workload Units	\$1,476,000	\$738,000	\$738,000
<b>Total</b>	<b>\$1,912,000</b>	<b>\$956,000</b>	<b>\$956,000</b>
<b>FY 2014-15</b>			
Administrative	\$436,000	\$218,000	\$218,000
Workload Units	\$1,476,000	\$738,000	\$738,000
<b>Total</b>	<b>\$1,912,000</b>	<b>\$956,000</b>	<b>\$956,000</b>

**Funding:**

100 %Title XIX (4260-101-0890)

## CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER: 76  
 IMPLEMENTATION DATE: 7/2001  
 ANALYST: Sandra Bannerman  
 FISCAL REFERENCE NUMBER: 257

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$651,000	\$651,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$651,000	\$651,000

### DESCRIPTION

**Purpose:**

This policy change estimates and reimburses the California Health and Human Services (CHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

**Authority:**

Interagency Agreement 11-88125

**Interdependent Policy Changes:**

Not Applicable

**Background:**

A HIPAA office has been established at the CHHS Agency to coordinate implementation and set policy requirements for departments utilizing Title XIX funding. This funding supports State positions and contracted staff to assist in the implementation of HIPAA rules at the Agency level. These staff provide oversight and subject matter expertise in HIPAA rules.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

- The budget for the CHHS Agency HIPAA activities has been frozen since FY 2008-09. The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

	DHCS FF	CHHS GF
<b>Cash Basis</b>		
<b>FY 2013-14:</b>	<b>\$651,000</b>	\$651,000
<b>FY 2014-15:</b>	<b>\$651,000</b>	\$651,000

**Funding:**

100% HIPAA (4260-117-0890)

## MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 77  
 IMPLEMENTATION DATE: 7/2003  
 ANALYST: Joanne Peschko  
 FISCAL REFERENCE NUMBER: 263

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$195,000	\$195,000
STATE FUNDS	\$97,500	\$97,500
FEDERAL FUNDS	\$97,500	\$97,500

### DESCRIPTION

**Purpose:**

This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

**Authority:**

Interagency Agreement #03-75683

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system, so the Merit System Services was established under the CalHR to perform as a personnel board for the 30 counties that do not have one. In addition, the CalHR reviews the merit systems in the remaining 28 counties to ensure that they meet federal civil service requirements.

The Department reimburses the CalHR via an IA for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

**Reason for Change from Prior Estimate:**

Additional expenditures in FY 2013-2014 reflecting increased frequency of audits and hiring exams offered.

**Methodology:**

The estimates, on a cash basis, were provided by CalHR.

**Funding:**

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

## FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTREACH

OTHER ADMIN. POLICY CHANGE NUMBER: 78  
 IMPLEMENTATION DATE: 12/1999  
 ANALYST: Randolph Alarcio  
 FISCAL REFERENCE NUMBER: 248

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$53,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$53,000	\$0

### DESCRIPTION

**Purpose:**

This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for provider recruitment, education, and support for the Family Planning, Access, Care, and Treatment (Family PACT) program.

**Authority:**

Interagency Agreement 08-85180

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The Family PACT program has two main objectives. One is to increase access to services for low-income women and men, including adolescents. The other is to increase the number of providers who serve these clients. The Department provides education and support services to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach,
- Provider enrollment, recruitment, and training,
- Training and technical assistance for medical and non-medical staff,
- Education and counseling services,
- Preventive clinical services,
- Sexually transmitted infection/HIV training and technical assistance services, and
- Toll-free referral number.

The Office of Family Planning in the CDPH contracts with a variety of entities to provide these services.

The Family PACT program and funding transferred to the Department, effective July 1, 2012. See the Family PACT Program Admin. policy change for administrative costs beginning July 1, 2012 and after.

**Reason for Change from Prior Estimate:**

Updated actual FFP reimbursement amounts for administrative services in FY 2011-12.

**Methodology:**

1. CDPH provides the General Fund match on a cash basis.

**FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTREACH**

OTHER ADMIN. POLICY CHANGE NUMBER: 78

2. The previously authorized expenditures expected to be paid in FY 2013-14 are:

	<u>TF</u>	<u>CDPH GF</u>	<u>DHCS FF</u>
FY 2011-12 expenditures	\$106,000	\$53,000	\$53,000
<b>Total FY 2013-14</b>	<b>\$106,000</b>	<b>\$53,000</b>	<b>\$53,000</b>

**Funding:**

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

## PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 79  
 IMPLEMENTATION DATE: 7/2003  
 ANALYST: Erickson Chow  
 FISCAL REFERENCE NUMBER: 1114

	FY 2013-14	FY 2014-15
TOTAL FUNDS	\$324,000	\$360,000
STATE FUNDS	\$162,000	\$180,000
FEDERAL FUNDS	\$162,000	\$180,000

### DESCRIPTION

**Purpose:**

This policy change estimates the costs related to courier services for Prison Industry Authority (PIA) eyewear.

**Authority:**

Interagency Agreement (IA) #13-90175

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The California PIA fabricates eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an IA with PIA to reimburse them for one-half of the courier costs for the pick-up and delivery of orders to optical providers. The two-way courier service ensures that beneficiaries have continued access to and no disruption of optical services.

**Reason for Change from Prior Estimate:**

There is no change.

**Methodology:**

1. The current contract with West Coast Overnight, Incorporated began in April 2012 and expires in March 2014. The cost per package is \$1.625 plus a four percent fuel surcharge.
2. The contract will be renewed in April 2014 with the same amount of vendors.
3. Based on the transition of children from the Healthy Families Program to the Medi-Cal Program, CALPIA anticipates a total of 468,000 Medi-Cal jobs (RX orders). CALPIA shipments average 2.44 Medi-Cal jobs per package which equates to 192,000 shipments (468,000/2.44).

The annual cost is estimated to be:  $\$1.625 \times 1.04 \times 192,000 = \$324,000$  TF

	FY 2013-14	FY 2014-15
Cash Basis		
FY 2012-13 Services	\$ 90,000	\$ 0
FY 2013-14 Services	\$ 234,000	\$ 90,000
FY 2014-15 Services	\$ 0	\$ 270,000
<b>Total Fund</b>	<b>\$ 324,000</b>	<b>\$ 360,000</b>

## **PIA EYEWEAR COURIER SERVICE**

**OTHER ADMIN. POLICY CHANGE NUMBER: 79**

**Funding:**

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

## THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS

OTHER ADMIN. POLICY CHANGE NUMBER: 80  
 IMPLEMENTATION DATE: 12/2013  
 ANALYST: Julie Chan  
 FISCAL REFERENCE NUMBER: 1830

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
TOTAL FUNDS	\$250,000	\$250,000
STATE FUNDS	\$125,000	\$125,000
FEDERAL FUNDS	\$125,000	\$125,000

### DESCRIPTION

**Purpose:**

This policy change estimates the cost to procure a vendor, from the California Multiple Award Schedule, to conduct a third party validation of all Drug Medi-Cal (DMC) program service providers, pre and post certification.

**Authority:**

Not Applicable

**Interdependent Policy Changes:**

Not Applicable

**Background:**

The third party validation will enhance anti-fraud activities that will enable the Department to assess program providers, provider risk, demographic coverage, and generate alerts of changes in status by matching providers through various sources of information. Matching sources will include but are not limited to (a) Federal Exclusion Records; (b) State Exclusion Records; (c) Federal Death Records; (d) State Licensure Sanctions; and (e) National Provider Identification (NPI) Deactivations.

**Reason for Change from Prior Estimate:**

This is a new policy change.

**Methodology:**

1. The contractor is expected to start December 1, 2013.
2. The total contract cost is \$500,000.
3. Assume \$250,000 will be spent in each fiscal year.

**Funding:**

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

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## FISCAL INTERMEDIARY ESTIMATE

November 2013

<b>FY 2013-14</b>	<b>TOTAL</b>	<b>FEDERAL</b>	<b>STATE</b>
MEDICAL FISCAL INTERMEDIARY CONTRACT (a)	\$207,931,000	\$151,706,000	\$56,225,000
DENTAL FISCAL INTERMEDIARY CONTRACT (b)	\$82,337,000	\$56,115,000	\$26,222,000
HEALTH CARE OPTIONS (c)	\$122,126,000	\$63,757,000	\$58,369,000
STATE CONTROLLER/STATE TREASURER	\$1,856,000	\$1,147,000	\$709,000
PROVIDER VERIFICATION FILE	\$2,000	\$1,000	\$1,000
<b>TOTAL MEDI-CAL COSTS</b>	<b><u>\$414,252,000</u></b>	<b><u>\$272,726,000</u></b>	<b><u>\$141,526,000</u></b>

Refugee expenditures of \$114,681 are included in the Reimbursement line (4260-610-0995) in the Management Summary.

(a) Includes \$8,597,923 TF (\$3,009,273 GF) for Title XXI activities (4260-113-0001/0890), and \$20,760,535 TF (\$3,700,604 GF) for HIPAA (4260-117-0001/0890).

(b) Includes \$88,000 TF (\$30,800 GF) for Title XXI activities (4260-113-0001/0890), and \$939,000 TF (\$234,750 GF) for HIPAA (4260-117-0001/0890).

(c) Includes \$17,962,000 TF (\$6,287,000 GF) for Title XXI activities (4260-113-0001/0890).

## FISCAL INTERMEDIARY ESTIMATE

November 2013

<b>FY 2014-15</b>	<b>TOTAL</b>	<b>FEDERAL</b>	<b>STATE</b>
MEDICAL FISCAL INTERMEDIARY CONTRACT (a)	\$250,541,000	\$189,713,000	\$60,828,000
DENTAL FISCAL INTERMEDIARY CONTRACT (b)	\$88,707,000	\$60,340,000	\$28,367,000
HEALTH CARE OPTIONS (c)	\$78,164,000	\$40,761,000	\$37,403,000
STATE CONTROLLER/STATE TREASURER	\$1,856,000	\$1,148,000	\$708,000
PROVIDER VERIFICATION FILE	\$2,000	\$1,000	\$1,000
<b>TOTAL MEDI-CAL COSTS</b>	<b><u>\$419,270,000</u></b>	<b><u>\$291,963,000</u></b>	<b><u>\$127,307,000</u></b>

Refugee expenditures of \$134,257 are included in the Reimbursement line (4260-610-0995) in the Management Summary.

(a) Includes \$8,597,923 TF (\$3,009,273 GF) for Title XXI activities (4260-113-0001/0890), and \$22,159,246 TF (\$2,631,527 GF) for HIPAA (4260-117-0001/0890).

(b) Includes \$340,000 TF (\$85,000 GF) for HIPAA (4260-117-0001/0890).

(c) Includes \$11,189,000 TF (\$3,916,000 GF) for Title XXI activities (4260-113-0001/0890).

### Fiscal Year 2013-14 Comparison

	<u>2013-14 Appropriation</u>		<u>Nov 2013 Estimate</u>		<u>Difference btwn. Nov 13 &amp; Appr.</u>	
	<u>Total Funds</u>	<u>State Funds</u>	<u>Total Funds</u>	<u>State Funds</u>	<u>Total Funds</u>	<u>State Funds</u>
Total Medical Fiscal Intermediary	\$180,393,000	\$49,650,000	\$207,931,000	\$56,225,000	\$27,538,000	\$6,575,000
Total Dental Fiscal Intermediary	\$74,158,000	\$23,631,000	\$82,337,000	\$26,222,000	\$8,179,000	\$2,591,000
Total Health Care Options	\$96,787,000	\$48,643,000	\$122,126,000	\$58,369,000	\$25,339,000	\$9,726,000
Total Miscellaneous Expenditures	\$1,858,000	\$709,000	\$1,858,000	\$710,000	\$0	\$1,000
<b>GRAND TOTAL</b>	<b>\$353,196,000</b>	<b>\$122,633,000</b>	<b>\$414,252,000</b>	<b>\$141,526,000</b>	<b>\$61,056,000</b>	<b>\$18,893,000</b>

### Fiscal Year 2013-14 Comparison

	<u>Nov 2013 Estimate</u>		<u>Difference btwn. CY and BY</u>	
	<u>Total Funds</u>	<u>State Funds</u>	<u>Total Funds</u>	<u>State Funds</u>
Total Medical Fiscal Intermediary	\$250,541,000	\$60,828,000	\$42,610,000	\$4,603,000
Total Dental Fiscal Intermediary	\$88,707,000	\$28,367,000	\$6,370,000	\$2,145,000
Total Health Care Options	\$78,164,000	\$37,403,000	(\$43,962,000)	(\$20,966,000)
Total Miscellaneous Expenditures	\$1,858,000	\$709,000	\$0	(\$1,000)
<b>GRAND TOTAL</b>	<b>\$419,270,000</b>	<b>\$127,307,000</b>	<b>\$5,018,000</b>	<b>(\$14,219,000)</b>

## **MEDICAL FISCAL INTERMEDIARY**

## MEDICAL FISCAL INTERMEDIARY

The Medi-Cal fiscal intermediary (FI) contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles.

The FI contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009. The contract effective date was May 3, 2010, which began the Takeover phase. During this phase HP Enterprise Services, LLC (HP) continued operations and work on Turnover activities through to the successful Assumption of Operations (AOO) by Xerox on October 3, 2011.

The main cost components of the FI contract are as follows:

**Operations** – Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of General and Online Drug Adjudicated Claim Lines (ACLs), Drug Use Review (DUR) inquiries, Encounter Claim Lines, California Eligibility Verification and Management Systems (CA-EVS/CMS) processing, Medicare Drug Discount Program, Treatment Authorization Requests and the Telephone Services Center (TSC). The FI has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

**Cost Reimbursement** – Various costs incurred by the Contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

- 1) Postage,
- 2) Parcel services and common carriers,
- 3) Personal computers, monitors, printers, related equipment, and software,
- 4) Printing,
- 5) Telephone toll charges,
- 6) Audio text equipment,
- 7) Data center access,
- 8) Special training sessions,
- 9) Facilities improvement and modifications,
- 10) Audits and research,
- 11) Sales tax,
- 12) Change orders,
- 13) The Medi-Cal Print and Distribution Center,
- 14) DUR and Eligibility Verification Telecommunications,
- 15) Field Office Automation Group (FOAG) equipment and furniture, and
- 16) IV&V Contracts

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Modifications resulting in changes to Contractor responsibilities, called Change Orders, are billed separately from the contract Operations. A Change Order is a documentable increase of effort identified as having a direct relation to the administration of the Contract that is above the volume of the required work within the scope, and above the normal fixed-price of the Contract.

**Hourly Reimbursement** – Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG) and FOAG Pharmacists. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the CA-MMIS. FOAG staff perform automation related tasks, such as preparing Treatment Authorization Request (TAR) batches and performing TAR data entries and corrections.

**Medical Fiscal Intermediary Summary  
November 2013**

**FY 2013-14**

	<b>Total Funds</b>	<b>State Funds</b>
Operations	\$94,102,032	\$30,589,808
Hourly Reimbursement	\$22,521,340	\$5,040,404
Cost Reimbursement	\$23,957,652	\$7,543,025
Other Estimated Costs	\$10,695,567	\$3,448,892
Change Orders	\$12,967,513	\$2,819,070
Healthy Families (XXI)	\$42,000	\$14,700
Enhancements	\$12,225,809	\$1,464,652
Optional Contractual Services	\$3,217,301	\$321,730
System Replacements	\$22,638,058	\$3,560,966
Family PACT	\$125,000	\$62,500
 Sub-Total	 \$202,492,272	 \$54,865,748
 Sales Tax	 \$5,438,744	 \$1,359,686
 <b>TOTAL MEDICAL FI COSTS</b>	 <b>\$207,931,016</b>	 <b>\$56,225,434</b>

**FY 2014-15**

	<b>Total Funds</b>	<b>State Funds</b>
Operations	\$93,322,893	\$30,394,235
Hourly Reimbursement	\$23,077,508	\$4,162,517
Cost Reimbursement	\$22,520,747	\$7,359,184
Other Estimated Costs	\$10,937,355	\$3,509,339
Change Orders	\$20,285,982	\$2,717,861
Healthy Families (XXI)	\$100,000	\$35,000
Enhancements	\$14,016,374	\$1,679,162
System Replacements	\$60,740,842	\$9,554,535
Family PACT	\$125,000	\$62,500
 Sub-Total	 \$245,126,701	 \$59,474,330
 Sales Tax	 \$5,414,404	 \$1,353,601
 <b>TOTAL MEDICAL FI COSTS</b>	 <b>\$250,541,105</b>	 <b>\$60,827,931</b>

**MEDICAL FISCAL INTERMEDIARY ESTIMATE (DETAIL TABLE)**

**November 2013**

<b>FY 2013-14</b>	<b>TOTAL FUNDS</b>
<b>OPERATIONS</b>	<b>\$94,102,032</b>
General ACLs	\$60,912,170
On-Line Pharmacy ACLs	\$4,503,015
DUR	\$380,000
Retrospective DUR	\$75,807
Encounter Claim Lines	\$1,614,000
CA-EVS/CMS Processing	\$5,400,000
Medicare Drug Discount Program	\$17,040
Treatment Authorization Requests	\$9,000,000
Telephone Services Center	\$12,200,000
<b>HOURLY REIMBURSEMENT</b>	<b>\$22,521,340</b>
Systems Group	\$21,969,892
Field Office Automation Group (FOAG)	\$551,448
<b>COST REIMBURSEMENT</b>	<b>\$23,957,652</b>
Postage	\$2,010,627
Parcel Services & Common Carriers	\$162,309
Equipment/Services	\$6,725,536
P&D and PUBS	\$2,022,419
Other Direct Costs	\$1,852,789
Facilities Improve/Modif	\$1,500,000
Audits & Research	\$225,720
Change Orders	\$500,000
Consultant Contracts	\$5,643,018
Telecommunication	\$2,639,287
Other Cost Reimbursable Items	\$675,947
<b>OTHER ESTIMATED COSTS</b>	<b>\$10,695,567</b>
Beneficiary ID Cards - BIC	\$1,500,000
Health Access Program Cards	\$270,000
Provision 11 & 57	\$1,625,567
RAIS Medi-Cal	\$1,200,000
RAIS MCO	\$3,000,000
Cost Containment	\$3,100,000
<b>CHANGE ORDERS</b>	<b>\$12,967,513</b>
Negotiated Change Orders	\$5,266,048
Change Orders in Progress	\$7,701,465
Unspecified Change Orders	\$0

*continued on next page*  
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CY Medical FI Estimate (Detail Table), November 2013 Estimate  
Continued from Page 8

<b>FY 2013-14</b>	<b>TOTAL FUNDS</b>
<b>ENHANCEMENTS</b>	<b>\$12,225,809</b>
HIPAA 5010	\$4,814,200
HIPAA ICD-10	\$3,302,383
BRE	\$4,109,226
<b>OPTIONAL CONTRACTUAL SERVICES</b>	<b>\$3,217,301</b>
HITECH	\$3,217,301
<b>SYSTEM REPLACEMENTS</b>	<b>\$22,638,058</b>
<b>HEALTHY FAMILIES (Title XXI only)</b>	<b>\$42,000</b>
<b>FAMILY PACT</b>	<b>\$125,000</b>
<b>SUBTOTAL</b>	<b>\$202,492,272</b>
<b>SALES TAX 8%</b>	<b>\$5,438,744</b>
<b>MEDICAL FI TOTAL FUND</b>	<b>\$207,931,016</b>

**MEDICAL FISCAL INTERMEDIARY ESTIMATE (DETAIL TABLE)**  
**November 2013**

<b>FY 2014-15</b>	<b>TOTAL FUNDS</b>
<b>OPERATIONS</b>	<b>\$93,322,893</b>
General ACLs	\$60,751,743
On-Line Pharmacy ACL s	\$4,454,303
DUR	\$310,000
Retrospective DUR	\$75,807
Encounter Claim Lines	\$1,614,000
CA-EVS/CMS Processing	\$4,400,000
Medicare Drug Discount Program	\$17,040
Treatment Authorization Requests	\$9,000,000
Telephone Services Center	\$12,700,000
<b>HOURLY REIMBURSEMENT</b>	<b>\$23,077,508</b>
Systems Group	\$22,526,060
Field Office Automation Group (FOAG)	\$551,448
<b>COST REIMBURSEMENT</b>	<b>\$22,520,747</b>
Postage	\$1,917,779
Parcel Services & Common Carriers	\$157,220
Equipment/Services	\$6,403,147
P&D and PUBS	\$2,079,966
Other Direct Costs	\$1,728,443
Change Orders	\$25,000
Consultant Contracts	\$4,889,972
Telecommunication	\$2,615,431
Other Cost Reimbursable Items	\$2,703,787
<b>OTHER ESTIMATED COSTS</b>	<b>\$10,937,355</b>
Beneficiary ID Cards - BIC	\$1,500,000
Health Access Program Cards	\$270,000
Provision 11 & 57	\$2,067,355
RAIS Medi-Cal	\$1,000,000
RAIS MCO	\$3,000,000
Cost Containment	\$3,100,000
<b>CHANGE ORDERS</b>	<b>\$20,285,982</b>
Negotiated Change Orders	\$0
Change Orders in Progress	\$20,285,982
Unspecified Change Orders	\$0

*continued on next page*

CY Medical FI Estimate (Detail Table), November 2013 Estimate  
Continued from Page 10

<b>FY 2014-15</b>	<b>TOTAL FUNDS</b>
<b>ENHANCEMENTS</b>	<b>\$14,016,374</b>
HIPAA 5010	\$0
HIPAA ICD-10	\$9,907,148
BRE	\$4,109,226
<b>SYSTEM REPLACEMENTS</b>	<b>\$60,740,842</b>
<b>HEALTHY FAMILIES (TITLE XXI ONLY)</b>	<b>\$100,000</b>
<b>FAMILY PACT</b>	<b>\$125,000</b>
<b>SUBTOTAL</b>	<b>\$245,126,701</b>
<b>SALES TAX 8%</b>	<b>\$5,414,404</b>
<b>MEDICAL FI TOTAL FUND</b>	<b>\$250,541,105</b>

**MEDICAL FISCAL INTERMEDIARY**

Assumptions

ACL Projections:

**FY 2013-14**

	<u>General ACLs</u>	<u>Amount</u>	<u>Online-Drug ACLs</u>	<u>Amount</u>
Total ACLs	174,691,173	\$60,967,234	39,660,491	\$4,507,754
Less HFP	173,875	\$55,065	46,721	\$4,739
<b>Total Medi-Cal ACLs</b>	<b>174,517,299</b>	<b>\$60,912,170</b>	<b>39,613,771</b>	<b>\$4,503,015</b>

Based on the estimated FY 2013-14 volumes, general ACLs are projected at \$0.35320 and online ACLs are projected at \$0.11438. ACLs are paid at different rates depending on the volume level. The average price is a blend of these rates and is determined by the actual annual volume of claims.

**FY 2014-15**

	<u>General ACLs</u>	<u>Amount</u>	<u>Online-Drug ACLs</u>	<u>Amount</u>
Total ACLs	211,966,809	\$60,799,742	40,079,108	\$4,459,215
Less HFP	330,797	\$47,999	91,010	\$4,912
<b>Total Medi-Cal ACLs</b>	<b>211,636,012</b>	<b>\$60,751,743</b>	<b>39,988,097</b>	<b>\$4,454,303</b>

Based on the estimated FY 2014-15 volumes, general ACLs are projected at \$0.29244 and online ACLs are projected at \$0.11261. ACLs are paid at different rates depending on the volume level. The average price is a blend of these rates and is determined by the actual annual volume of claims.

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
9	<b>Telephone Services Center Rate Adjustment for Contract Year 1</b>	06/27/2013

The current Fiscal Intermediary Contract with Xerox utilizes the Base Volume Method of Payment (BVMP) for the Medi-Cal Telephone Service Center (TSC). If for any reason, the actual yearly volume of calls exceeds the maximum annual volume listed for any Contract Year, the Contract allows for the negotiation of a new rate via the change order process. This change order negotiates payment for the yearly volume of TSC calls that exceeded the high volume maximum listed in Contract Year 1 (October 3, 2011 through June 30, 2012).

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$742,388	\$0
General Funds	\$215,478	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$742,388	\$0
General Funds	\$215,478	\$0

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
11	<b>Encounter Claim Line BVMP for Contract Year 1</b>	6/27/2013

The current Fiscal Intermediary Contract with Xerox utilizes the Base Volume Method of Payment for the Encounter Claim Lines (ECL) volume. If for any reason, the actual yearly volume of ECL exceeds the maximum annual volume listed for any Contract Year, the Contract allows for the negotiation of a new rate via the change order process. This change order negotiates payment for the yearly volume of ECL that exceeded the high volume maximum listed in Contract Year 1 (October 3, 2011 through June 30, 2012).

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$212,704	\$0
General Funds	\$53,176	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$212,704	\$0
General Funds	\$53,176	\$0

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
14	<b>MITA 2.0 to 3.0 Gap Analysis</b>	7/3/2013

The current Fiscal Intermediary Contract with Xerox allows compensation to Xerox for required increase in work effort that is above the volume of the work required within the scope, and above the normal fixed price of the Contract through the Change Order process. As a result of Federal legislation and Centers for Medicare and Medicaid Services policy initiatives, Xerox provided technical staff to perform a Gap Analysis of the transition from MITA 2.0 to 3.0.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$55,075	\$0
General Funds	\$13,769	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$55,075	\$0
General Funds	\$13,769	\$0

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
15	<b>Encounter Claim Lines BVMP for Contract Year 2 (Phase I)</b>	5/30/2013

The current Fiscal Intermediary Contract with Xerox utilizes the Base Volume Method of Payment for the Encounter Claim Lines (ECL) volume. If for any reason, the actual yearly volume of ECL exceeds the maximum annual volume listed for any Contract Year, the Contract allows for the negotiation of a new rate via the change order process. This change order negotiates payment for the yearly volume of ECL that exceeded the high volume maximum listed for the first 6 months of Contract Year 2 (July 1, 2012 through December 31, 2012).

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$179,481	\$0
General Funds	\$44,870	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$179,481	\$0
General Funds	\$44,870	\$0

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
17	<b>Rebate Accounting and Information System for MCO for Contract Year 1</b>	6/25/2013

RAIS calculates federally-negotiated Medicaid rebates due to the states from drug manufacturers. The current Fiscal Intermediary Contract with Xerox allows compensation to Xerox for required increase in work effort that is above the volume of the work required within the scope, and above the normal fixed price of the Contract through the Change Order process. This change order negotiates payment for the yearly RAIS Managed Care Organization transactions that were processed in Contract Year 1 (October 3, 2011 through July 6, 2012). Rebate transactions processed by Xerox bring in revenue to the Department.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$1,404,313	\$0
General Funds	\$351,078	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$1,404,313	\$0
General Funds	\$351,078	\$0

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
18	<b>Rebate Accounting and Information System for MCO for Contract Year 2 (Phase I)</b>	6/25/2013

RAIS calculates federally-negotiated Medicaid rebates due to the states from drug manufacturers. The current Fiscal Intermediary Contract with Xerox allows compensation to Xerox for required increase in work effort that is above the volume of the work required within the scope, and above the normal fixed price of the Contract through the Change Order process. This change order negotiates payment for the yearly RAIS Managed Care Organization transactions that were processed in during the first 9 months of Contract Year 2 (July 7, 2012 through March 31, 2013). Rebate transactions processed by Xerox bring in revenue to the Department.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$2,672,087	\$0
General Funds	\$668,022	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$2,672,087	\$0
General Funds	\$668,022	\$0

**Change Orders in Progress**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
12	<b>Diagnosis Related Groups</b>	TBD

Senate Bill (SB) 853 requires the Department to develop and implement a Medi-Cal payment methodology based on Diagnostic Related Groups (DRG). The DRG reflects the costs and staffing levels associated with quality of care for patients unless otherwise specified. The Department has agreed to reimburse Xerox for all documentable expenses that are as a direct result of efforts to implement the DRG requirement. Reimbursable expenses are for required work that is beyond the scope of the current Fiscal Intermediary Contract with Xerox.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$645,000	\$1,145,460
General Funds	\$322,500	\$572,730
<b>Cost Reimbursement:</b>		
Total Funds	\$500,000	\$25,000
General Funds	\$250,000	\$12,500
Total Funds	\$1,145,000	\$1,170,460
General Funds	\$572,500	\$585,230

**Change Orders in Progress**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
13	<b>ICD-10 Enhancement – Revised Architecture</b>	TBD

The Department of Health and Human Services has published the Final Rule that requires replacing the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM) code sets with the greatly expanded ICD-10 diagnosis and procedure code sets, effective October 1, 2014. Updated versions of current Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction standards will be needed in order to accommodate the ICD-10 code sets for claims, remittance advices, eligibility inquiries, referral authorization and other transactions. This enhancement modifies CA-MMIS to ensure compliance with HIPAA Rules.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$4,400,000	\$17,600,000
General Funds	\$440,000	\$1,760,000
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$4,400,000	\$17,600,000
General Funds	\$440,000	\$1,760,000

**Change Orders in Progress**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
16	<b>Telephone Services Center Rate Adjustment for Contract Year 2</b>	TBD

The current Fiscal Intermediary Contract with Xerox utilizes the Base Volume Method of Payment (BVMP) for the Medi-Cal Telephone Service Center (TSC). If for any reason, the actual yearly volume of calls exceeds the maximum annual volume listed for any Contract Year, the Contract allows for the negotiation of a new rate via the change order process. This change order negotiates payment for the yearly volume of TSC calls that exceeded the high volume maximum listed in Contract Year 2 (July 1, 2012 through June 30, 2013).

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$1,144,367	\$0
General Funds	\$332,153	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$1,144,367	\$0
General Funds	\$332,153	\$0

**Change Orders in Progress**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
19	<b>Encounter Claim Lines BVMP for Contract Year 2 (Phase II)</b>	TBD

The current Fiscal Intermediary Contract with Xerox utilizes the Base Volume Method of Payment for the Encounter Claim Lines (ECL) volume. If for any reason, the actual yearly volume of ECL exceeds the maximum annual volume listed for any Contract Year, the Contract allows for the negotiation of a new rate via the change order process. This change order negotiates payment for the yearly volume of ECL that exceeded the high volume maximum listed for the last 6 months of Contract Year 2 (January 1, 2013 through June 29, 2013).

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$203,282	\$0
General Funds	\$50,821	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$203,282	\$0
General Funds	\$50,821	\$0

**Change Orders in Progress**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
20	<b>Rebate Accounting and Information System for MCO for Contract Year 2 (Phase II)</b>	TBD

RAIS calculates federally-negotiated Medicaid rebates due to the states from drug manufacturers. The current Fiscal Intermediary Contract with Xerox allows compensation to Xerox for required increase in work effort that is above the volume of the work required within the scope, and above the normal fixed price of the Contract through the Change Order process. This change order negotiates payment for the yearly RAIS Managed Care Organization transactions that were processed in during the last 3 months of Contract Year 2 (April 1, 2013 through July 5, 2013). Rebate transactions processed by Xerox bring in revenue to the Department.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$1,000,000	\$1,000,000
General Funds	\$250,000	\$250,000
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$1,000,000	\$1,000,000
General Funds	\$250,000	\$250,000

**Change Orders in Progress**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
21	<b>AB97 Erroneous Payment Corrections</b>	TBD

Assembly Bill (AB) 97 authorized the Department to make reductions to payments made to Medi-Cal providers. This change order reimburses Xerox for all documentable expenses that are as a direct result of efforts to implement the AB97. Reimbursable expenses are for required work that is beyond the scope of the current Fiscal Intermediary Contract with Xerox.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$308,816	\$540,522
General Funds	\$77,204	\$135,131
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$308,816	\$540,522
General Funds	\$77,204	\$135,131

## DENTAL FISCAL INTERMEDIARY

## DENTAL FISCAL INTERMEDIARY

In 1997, the State awarded Delta Dental Plan of California (DDC) a contract which took effect in February of 1998. Full Operations of this contract ended in April 2005. In 2004, the State again awarded Delta (now Delta Dental of California) a contract with Takeover activities commencing on November 1, 2004. Full Operations, including claims processing, began May 1, 2005 and was scheduled to end June 30, 2012. The Department issued a Request for Proposal and published the Notice of Intent to Award in August 2011. However, CMS determined the new Medi-Cal Dental FI contract failed to meet the regulatory criteria and conditions as a Medicaid Management Information System (MMIS). Subsequently, the Department exercised the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013. The Department has received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension began July 1, 2013 and will go through June 30, 2015. During the extension, the Department plans to develop a Planning Advanced Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements. All activities related to the new contract have been delayed.

Assembly Bill 82 (Chapter 23, Statutes of 2013) restores select adult dental benefits to beneficiaries 21 years of age and older starting May 1, 2014.

The following covered medical benefits will be restored:

- Examinations, radiographs/photographic images, prophylaxis, fluoride treatments
- Amalgam and composite restorations
- Stainless steel, resin, and resin window crowns
- Anterior root canal therapy
- Complete dentures, including immediate dentures
- Complete denture adjustments, repairs, and relines

The Department will seek approval for federal financial participation and coverage of the above services.

The terms of the contract require DDC to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract. The three main payment categories for this contract include:

**Operations** - Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Dental Medicaid Management Information System (CD-MMIS). These cost categories consist of General Adjudicated Claim Service Lines (ACSLs), Treatment Authorization Requests (TARS), and Telephone Support Center (TSC). DDC has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

**Cost Reimbursement** - Various costs incurred by the Contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of

the contract. Any of the following costs may be cost reimbursed under the contract:

- 1) Printing,
- 2) Data center access,
- 3) Postage, parcel services, and common carriers,
- 4) Special training sessions, convention, and travel,
- 5) Audits and research,
- 6) Facilities improvement,
- 7) Personal computers, monitors, printers, related equipment, and software,
- 8) Telephone toll charges,
- 9) Knox Keene License Annual Assessment, and
- 10) Miscellaneous.

Costs under these categories consist of direct costs, or a subset thereof, which can be specifically identifiable with the particular cost objective.

**Hourly Reimbursement** - Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG), Surveillance and Utilization Review (SURS) unit, and computer support. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the CD-MMIS. The SURS staff consists of dental consultants, manager/supervisors, liaisons, and analysts that monitor the provider and beneficiary claims to prevent potential fraud and abuse.

**Dental Fiscal Intermediary  
November 2013**

**FY 2013-14**

	<u><b>Total Fund</b></u>	<u><b>General Fund</b></u>
Dental Administration/Operations	\$45,393,000	\$12,522,794
Telephone Service Center	\$15,387,000	\$6,501,008
Change Orders	\$1,951,000	\$900,500
Hourly Reimbursable Groups	\$11,855,200	\$2,963,800
Cost Reimbursable Expenses	\$6,069,000	\$2,913,000
Contract Turnover	\$775,000	\$193,750
Contract Takeover	<u>\$907,000</u>	<u>\$226,750</u>
<b>Total Dental Administration Costs</b>	<u><b>\$82,337,200</b></u>	<u><b>\$26,221,602</b></u>

**Dental Fiscal Intermediary  
November 2013**

**FY 2014-15**

	<u><b>Total Fund</b></u>	<u><b>General Fund</b></u>
Dental Administration Operations	\$50,000,000	\$13,793,750
Telephone Service Center	\$17,524,000	\$7,403,890
Change Orders	\$2,223,000	\$1,034,000
Hourly Reimbursable Groups	\$12,115,700	\$3,028,925
Cost Reimbursable Expenses	\$6,069,000	\$2,913,000
Contract Turnover	<u>\$775,000</u>	<u>\$193,750</u>
<b>Total Dental Administration Costs</b>	<u><u><b>\$88,706,700</b></u></u>	<u><u><b>\$28,367,315</b></u></u>

**DENTAL COST REIMBURSABLE EXPENSES**

**November 2013**

	FY 2013-14		FY 2014-15	
	TF	GF	TF	GF
Printing (50%)	\$800,000	\$400,000	\$800,000	\$400,000
Data Center Access/CPU Usage (25%)	\$1,000	\$250	\$1,000	\$250
Postage / Parcel Service (50%)	\$1,400,000	\$700,000	\$1,400,000	\$700,000
Special Training,Convention, Travel (50%)	\$130,000	\$65,000	\$130,000	\$65,000
Audits / Research (50%)	\$165,000	\$82,500	\$165,000	\$82,500
Facilities Improvement (25%)	\$110,000	\$27,500	\$110,000	\$27,500
Toll Free Phone Charges (25%)	\$375,000	\$93,750	\$375,000	\$93,750
Knox-Keene Annual Assessment (50%)	\$2,898,000	\$1,449,000	\$2,898,000	\$1,449,000
Misc. (50%)	\$190,000	\$95,000	\$190,000	\$95,000
<b>Total</b>	<b>\$6,069,000</b>	<b>\$2,913,000</b>	<b>\$6,069,000</b>	<b>\$2,913,000</b>

**DENTAL FISCAL INTERMEDIARY  
ACSL & TAR PROJECTIONS**

**November 2013**

**FY 2013-14 Assumptions**

- |                     |            |                                    |
|---------------------|------------|------------------------------------|
| ➤ ACSL Projections: | 30,063,647 | \$39,136,000                       |
| ➤ TAR Projections:  | 328,042    | <u>\$6,257,000</u><br>\$45,393,000 |
- Full, ongoing costs will be incurred for all contract pricing components.
  - FFP for postage, printing, Knox-Keene and Dental Outreach are funded at 50%.
  - Expenditures for all remaining administrative cost categories will be funded at 75% FFP.

**FY 2014-15 Assumptions**

- |                    |            |                                    |
|--------------------|------------|------------------------------------|
| ➤ ACSL Projections | 33,547,426 | \$43,353,000                       |
| ➤ TAR Projections  | 367,277    | <u>\$6,647,000</u><br>\$50,000,000 |
- Full, ongoing costs will be incurred for all contract pricing components.
  - FFP for postage, printing, Knox-Keene and Dental Outreach are funded at 50%.
  - Expenditures for all remaining administrative cost categories will be funded at 75% FFP.

## Negotiated Change Orders

<u>Change Order No.</u>	<u>Title/ Description</u>	<u>Effective</u>
7	<b>Conlan, Schwarzmer, Stevens vs. Bontá</b>	7/1/2007

In the case of *Conlan, Schwarzmer, Stevens v. Bontá*, the Court of Appeals found that the Department failed to provide a procedure whereby Medi-Cal beneficiaries can be reimbursed for their out-of-pocket expenses for health care received during their period of retroactive eligibility and during the period between their application for Medi-Cal and their determination of eligibility. The Court held that the Department's system of relying upon the beneficiaries to obtain reimbursement from the providers for these expenses is insufficient, because it violates the comparability provisions of the Medicaid law.

The Department has developed and implemented new processes through the Dental fiscal intermediary (FI) to ensure prompt reimbursement to beneficiaries. The Dental FI is required to hire, train, and oversee appropriate staff to address this new workload. Costs have been updated based on the current workload volume the Dental FI is receiving.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$100,000	\$100,000
General Funds	\$50,000	\$50,000

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/ Description</u>	<u>Effective</u>
9	<b>Health Insurance Portability and Accountability Act (HIPAA) Addendum - Security Risk Assessment</b>	8/1/2007

This change order establishes the Department's implementation plan designed to comply with the controls required by the National Institute of Standards and Technology (NIST). Special Publication 800-53 adds to the framework of OMB Circular No. A-130. Compliance with the NIST controls will result in increased requirements to the Security and Privacy Laws and regulations required by Contract 04-35745, Exhibit H, the HIPAA Business Associate Addendum. The results of this change order will be the implementation of a security risk assessment process for all current and future projects.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$300,000	\$310,000
General Funds	\$75,000	\$77,500

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/ Description</u>	<u>Effective</u>
23	<b>Federal Rule – Revalidation of Provider Enrollment</b>	6/1/2013

Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal Dental Program. The new rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children’s Health Insurance Program providers at the federal and state levels.

To stay in compliance, the Department plans to hire additional FI staff to complete the increased workload. The change order was approved in May 2013 and became effective June 2013. The FI plans to recruit additional staff and start incurring costs beginning October 2013.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$1,281,000	\$1,438,000
General Funds	\$640,500	\$719,000

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/ Description</u>	<u>Effective</u>
24	<b>Federal Rule – Database Checks</b>	6/1/2013

Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal Dental Program. The new rules establish requirements for screening of Medicare, Medicaid, and Children’s Health Insurance Program providers at the federal and state levels.

To stay in compliance, the Department plans to hire additional FI staff to complete the increased workload. The change order was approved in May 2013 and became effective June 2013. The FI plans to recruit additional staff and start incurring costs beginning October 2013.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$270,000	\$375,000
General Funds	\$135,000	\$187,500

## HEALTH CARE OPTIONS

## HEALTH CARE OPTIONS

The enrollment contractor, commonly referred to as Health Care Options (HCO), is responsible for enrolling Medi-Cal beneficiaries into Medi-Cal managed care health plans in 14 Two-Plan model counties and two Geographic Managed Care counties. The enrollment contractor also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

MAXIMUS, Inc. has been the contractor for HCO since October 1, 1996. Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months with three one-year optional extension years, plus an Extended Operations Period. Funds paid on the contract use a mixture of federal financial participation (50/50 for Administration; 75/25 for CHIPRA; and 65/35 for MCHIP).

**HEALTH CARE OPTIONS**  
**November 2013**  
**FY 2013-14**

**CONTRACT NO. 07-65829:**

**Operations:**

Section 8.3.2	Transactions	\$10,243,376	
Section 8.3.3	Mailings	\$7,185,153	
Section 8.3.47	Beneficiary Direct Assistance	\$4,473,347	
	Personalized Provider Directory	\$429,099	
	SPD County Inserts - Incremental Costs	\$57,738	
	Medi-Cal Publications Management Services	\$378,848	
	Initial Health Screen Questionnaire (MET/HIF)	\$165,115	
	CCI Booklets - Incremental Costs	\$634,759	
	Base Volume Increase Projection	\$13,749,199	
	Prior year unpaid invoices (April & May)	\$8,309,967	
	<i>Total Operations</i>	<u>\$45,626,601</u>	<u>\$20,883,247</u>
<b>Hourly Reimbursement:</b>			
Section 8.6	Enrollment Services Representatives	\$12,407,722	\$6,203,861
<b>Cost Reimbursement</b>			
Section 8.7	Various	\$29,560,798	\$14,780,399
<b>Personalized Provider Directories (PPD)</b>		(\$2,000,000)	(\$1,000,000)
<b>Coordinated Care Initiative (CCI) - Cal MediConnect and MLTSS</b>		\$21,588,937	\$10,794,469
<b>Transition of Healthy Families Children to Medi-Cal Admin. Costs</b>		\$8,415,434	\$2,945,402
<b>Low Income Health Program (LIHP) Implementation</b>		\$5,576,797	\$2,788,399
<b>Managed Care Expansion to Rural Counties</b>		\$4,212,563	\$2,106,282
<b>Change Orders</b>		(\$3,262,835)	(\$1,133,332)
<b>TOTAL HEALTH CARE OPTIONS FY 2013-14 ESTIMATE</b>		<u><u>\$122,126,017</u></u>	<u><u>\$58,368,726</u></u>

**HEALTH CARE OPTIONS**  
**November 2013**  
**FY 2014-15**

**CONTRACT NO. 07-65829:**

**Operations:**

Section 8.3.2	Transactions	\$10,434,755
Section 8.3.3	Mailings	\$7,562,211
Section 8.3.47	Beneficiary Direct Assistance	\$4,661,774
	Personalized Provider Directory	\$443,688
	SPD County Inserts - Incremental Costs	\$63,512
	Medi-Cal Publications Management Services	\$384,954
	Initial Health Screen Questionnaire (MET/HIF)	\$169,242
	CCI Booklets - Incremental Costs	\$930,980

	<u>Total Fund</u>	<u>General Fund</u>
<i>Total Operations</i>	\$24,651,116	\$11,085,066

**Hourly Reimbursement:**

Section 8.6	Enrollment Services Representatives	\$13,373,388	\$6,686,694
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**Cost Reimbursement:**

Section 8.7.1	Various	\$30,976,878	\$15,488,439
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<b>Personalized Provider Directories (PPD)</b>	(\$2,000,000)	(\$1,000,000)
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<b>Coordinated Care Initiative (CCI) - Cal MediConnect and MLTSS</b>	\$7,563,177	\$3,781,589
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<b>Transition of Healthy Families Children to Medi-Cal Admin Costs</b>	\$2,918,708	\$1,021,548
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<b>Managed Care Expansion to Rural Counties</b>	\$117,851	\$58,926
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<b>Beneficiary Dental Exception (BDE)</b>	\$498,955	\$249,478
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<b>Change Orders</b>	\$63,512	\$31,756
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<b>TOTAL HEALTH CARE OPTIONS FY 2014-15 ESTIMATE</b>	<u><u>\$78,163,585</u></u>	<u><u>\$37,403,494</u></u>
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## Personalized Provider Directories (PPDs)

HCO currently prints and mails health plan Provider Directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. AB 203 (Chapter 188, Statutes of 2007) authorized the implementation of a Personalized Provider Directory (PPD) as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the Personalized Provider Directories were determined in consultation with health plans and stakeholders. The pilot project began on February 27, 2009 and will continue. At the end of the pilot project period, the Department, in consultation with health plans and stakeholders, performed an assessment to determine if PPDs provide more accurate, up-to-date provider information to Medi-Cal managed care beneficiaries, in a smaller, standardized, and user-friendly format that results in a reduction of default assignments, and if they should be implemented statewide in all managed care counties.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Fixed-Price Costs	\$402,459	\$402,459
Cost Reimbursement	\$47,904	\$47,904
Savings (Printing and Postage)	(\$2,450,363)	(\$2,450,363)
Total Funds	(\$2,000,000)	(\$2,000,000)
General Fund	(\$1,000,000)	(\$1,000,000)

## **CCI - Cal MediConnect and Managed Long Term Support Services**

The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP), and other Home and Community-Based Services (HCBS) from fee-for-service into managed care health plans. Notices and packets will be mailed to beneficiaries.

In addition, to ensure a seamless enrollment selection process for beneficiaries impacted by the upcoming Coordinated Care Initiate (CCI) programs, costs have been included for a beneficiary-centric specialized call center. The beneficiaries covered under this project will have a dedicated toll free number, which directs them to their own specialized team of CCI experts who will guide them through the enrollment process and be able to answer all the Medi-Cal and Medicare questions.

	<b><u>FY 2013-14</u></b>	<b><u>FY 2014-15</u></b>
Total Funds	\$21,588,937	\$7,563,177
General Funds	\$10,794,469	\$3,781,589

## Transition of Healthy Families Children to Medi-Cal Admin Costs

AB 1494 (Chapter 28, Statutes of 2012) requires, effective January 1, 2013, that children subscribed in the HFP will be transitioned into Medi-Cal through a phase-in methodology. Coverage of this population under Medicaid programs is permissible pursuant to the federal Social Security Act to provide full scope Medi-Cal benefits to such eligible children who are optional targeted low-income children with family incomes up to and including 250% of the federal poverty level (FPL).

In pursuing this option to cover these targeted low income children, the benefits and administrative costs provided to these children are eligible for enhanced federal funding of 65% under Title XXI. To the extent possible, the children will be mandatorily enrolled into Medi-Cal managed care delivery systems; and to the extent such delivery models are not available, benefits will be provided under Medi-Cal fee-for-service. Implementation is contingent upon receiving necessary federal approvals.

In December 2012, the Department and MRMIB started mailing notices to beneficiaries enrolled in Healthy Families regarding their transition to the Medi-Cal Managed Care program. Mailings include, but are not limited to; informing notices, frequently asked questions, reminder notices, confirmation letters and choice packets. The mailings will continue through 2013 and 2014.

	<u><b>FY 2013-14</b></u>	<u><b>FY 2014-15</b></u>
Operation Allocation	\$12,867,021	\$8,269,950
Healthy Family Transition	\$8,415,434	\$2,918,708
Less: Change Order #3	<u>(\$3,320,573)</u>	<u>(\$0)</u>
 Total Funds	 \$17,961,882	 \$11,188,658
 General Funds	 \$6,286,659	 \$3,916,030

## Low Income Health Program (LIHP) Implementation

California's Bridge to Reform Demonstration expands coverage to eligible low income adults through the Low Income Health Program (LIHP). The LIHP consists of the Medicaid Coverage Expansion, effective July 1, 2011, through December 31, 2013, at which time the majority of enrollees will become Medi-Cal eligible under Affordable Care Act. These individuals will transition into Medi-Cal managed care beginning January 1, 2014. The Department is planning for the transition of the LIHP population.

The Department will develop beneficiary notices informing beneficiaries of the transition process. Beginning November 1, 2013, approximately 500,000 notices are scheduled to be mailed to beneficiaries. Due to the expanded scope of the project, there will be associated costs beginning in FY 2013-14.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$5,576,797	\$0
General Funds	\$2,788,399	\$0

## Managed Care Expansion to Rural Counties

Managed care is currently in 30 counties. AB 1467 (Chapter 23, Statutes of 2012) 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.

The first phase of expansion will be implemented on September 1, 2013 in the eight County Organized Health System (COHS) counties, and will be followed by the remaining 20 counties (Two-Plan, Geographic Managed Care-Plan and Single-Plan models) on November 1, 2013. Informing material mailings to beneficiaries (special notices, frequently asked questions, and special packets) started for COHS counties in July 2013.

The 20 Two-Plan, GMC-Plan, and Single-Plan model counties will require newly established enrollment presentation sites and the hiring, training and equipment costs associated with staffing these county enrollment sites. County site staffing will start during the third quarter of 2013.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$4,212,563	\$117,851
General Funds	\$2,106,282	\$58,926

## Beneficiary Dental Exception

Assembly Bill 1467 was enacted July 1, 2012 to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental managed care plans in Sacramento County. The intent of the Legislature is to improve access to dental care by implementation of the Beneficiary Dental Exception (BDE) process. The BDE is available to beneficiaries in Sacramento County who are unable to secure services through their dental plan, in accordance with applicable contractual timeframes and the Knox-Keene Health Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). The BDE allows a beneficiary to opt-out of Medi-Cal Dental Managed Care and move into fee-for-service (Denti-Cal).

The BDE notifications will be mailed to beneficiaries in Sacramento County. New enrollees will receive a BDE notification after they have been enrolled in a dental plan for 90 days based on the initial effective date of the enrollment transaction. The effective date for the first mailing for the 90 day BDE notification is August 1, 2013. Thereafter, currently enrolled beneficiaries will receive a BDE notification on an annual basis. The first mailing for the annual notification is September 1, 2013. The Department will incur additional costs for these mailings.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$0	\$498,955
General Funds	\$0	\$249,478

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
2	<b>SPD Mandatory Enrollment into Managed Care HCO Costs – Special Packet Inserts</b>	6/1/2011

Effective June 1, 2011, it is mandatory for all newly eligible Medi-Cal Only Seniors and Persons with Disabilities (SPDs) residing in managed care counties to enroll in a managed care plan. As a result, MAXIMUS, the Health Care Options (HCO) enrollment broker, is sending a special SPD informing materials packet county-specific insert to each SPD beneficiary upon transitioning to a mandatory status for enrollment. This special insert resulted in an additional incremental cost to each SPD informing materials packet for newly eligible SPDs.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$57,738	\$63,512
General Funds	\$28,869	\$31,756
<b>Cost Reimbursement:</b>		
Total Funds	\$0	\$0
General Funds	\$0	\$0
Total Funds	\$57,738	\$63,512
General Funds	\$28,869	\$31,756

**Negotiated Change Orders**

<u>Change Order No.</u>	<u>Title/Description</u>	<u>Effective</u>
3	<b>Healthy Families Transition to Medi-Cal Managed Care – Special Outbound Telephone Call Campaigns/Surveys</b>	7/17/2013

This change order authorizes Enrollment Broker to handle all the operational requirements for the implementation of the Healthy Families (HFP) Special Outbound Telephone Call Campaign/Surveys and other associated telephone call activities for the transition of HFP beneficiaries into Medi-Cal Managed Care. MAXIMUS will be required to hire and train Customer Service Representatives for the Telephone Call Center (TCC) to conduct the Special Outbound Telephone Call Campaign/Surveys under the Welfare and Institutions Code Section 14180 and California Section 1115 Comprehensive Medicaid Demonstration Project Waiver for the Healthy Families population into Medi-Cal Managed Care Program.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
<b>Change Order Administration:</b>		
Total Funds	\$2,829,438	\$0
General Funds	\$990,303	\$0
<b>Cost Reimbursement:</b>		
Total Funds	\$491,135	\$0
General Funds	\$171,897	\$0
Total Funds	\$3,320,573	\$0
General Funds	\$1,162,200	\$0

**MISCELLANEOUS  
EXPENDITURES**

**CALIFORNIA STATE CONTROLLER AND CALIFORNIA STATE TREASURER  
AGREEMENTS**

Pursuant to an interagency agreement with the Department, the California State Controller's Office (CSCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption.

CSCO Assumptions

- 75% FFP is claimed for CSCO costs related to warrant and Remittance Advice Detail (RAD) production. Due to all costs associated with the Medically Indigent Adult SNF cases being 100% payable from the General Fund, the net effective FFP ratio is 74.9%.
- 50% FFP is claimed for postage costs.
- 100% FFP is claimed for auditing services.

CSTO Assumptions

- 75% FFP is claimed for all CSTO costs related to warrant redemption services.

<b><u>FY 2013-14 Estimate</u></b>	<u>Total</u>	<u>GF</u>	<u>FFP</u>
CSCO			
Warrants & RADs	\$793,617	\$198,404	\$595,212
Postage	\$981,383	\$490,692	\$490,692
SCO Total	<b>\$1,775,000</b>	<b>\$689,096</b>	<b>\$1,085,904</b>
 CSTO			
Warrant Redemption	\$80,652	\$20,163	\$60,489
<b>TOTAL</b>	<b>\$1,855,652</b>	<b>\$709,259</b>	<b>\$1,146,393</b>

<b><u>FY 2014-15 Estimate</u></b>	<u>Total</u>	<u>GF</u>	<u>FFP</u>
CSCO			
Warrants & RADs	\$798,750	\$199,688	\$599,063
Postage	\$976,250	\$488,125	\$488,125
SCO Total	<b>\$1,775,000</b>	<b>\$687,813</b>	<b>\$1,087,188</b>
 CSTO			
Warrant Redemption	\$80,652	\$20,163	\$60,489
<b>TOTAL</b>	<b>\$1,855,652</b>	<b>\$707,976</b>	<b>\$1,147,677</b>

**PROVIDER VERIFICATION FILE**

Pursuant to an interagency agreement with the California Department of Consumer Affairs, Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify that prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Total Funds	\$2,466	\$2,466
General Funds	\$617	\$617

## HIPAA PROJECT SUMMARY

The Department's Medi-Cal fiscal intermediary HIPAA costs are displayed within the Systems Group (SG), Change Order (CO), and Cost Reimbursement (CR) for the HP and Delta Dental contracts and for the Maximus contract as follows:

	<u>FY 2013-14</u>		<u>FY 2014-15</u>	
Total Funds	\$27,112,512		\$25,748,542	
General Funds	\$3,787,552		\$4,346,835	
	<u>FY 2013-14</u>		<u>FY 2014-15</u>	
	Total Funds	GF	Total Funds	GF
<b>Medi-Cal Fiscal Intermediary</b>				
Code Conv/Secur/Trans (SG)	\$10,537,000	\$2,274,250	\$10,017,150	\$1,064,288
UPN Project Manager HIPAA-1 (CR)	\$116,580	\$29,145	\$0	\$0
ICD-10 HIPAA Medical Coders HIPAA-2 (CR)	\$249,920	\$29,491	\$300,000	\$35,400
Code Conversion Proj Mgr HIPAA-1 (CR)	\$116,580	\$29,145	\$0	\$0
ICD-10 Gap Analysis	\$466,672	\$46,667	\$933,328	\$93,333
5010 Legacy Enhancements	\$4,814,200	\$576,741	\$0	\$0
ICD-10 Enhancements	\$3,302,383	\$395,625	\$9,907,148	\$1,186,876
IV&V Contractor for HIPAA 5010 & ICD-10	\$55,000	\$6,490	\$275,000	\$32,450
HIPAA & State Privacy Breach Notification	\$150,000	\$75,000	\$150,000	\$75,000
Code Management Tool - Sof	\$450,000	\$112,500	\$450,000	\$112,500
PM for HIPAA ICD-10	\$101,760	\$25,440	\$0	\$0
HIPAA ICD-10 PM	\$253,440	\$63,360	\$126,720	\$31,680
Code Management Tool - Tra	\$147,000	\$36,750	\$0	\$0
<b>Total Medical FI</b>	<b>\$20,760,535</b>	<b>\$3,700,604</b>	<b>\$22,159,346</b>	<b>\$2,631,527</b>
<b>Dental</b>				
HIPAA Security (CO)	\$300,000	\$75,000	\$310,000	\$77,500
Development – CDT (SG) 25%	\$615,000	\$153,750	\$30,000	\$7,500
HIPAA 2 (SG)	\$0	\$0	\$0	\$0
HIPAA Operating Rules (SG) 25%	\$0	\$0	\$0	\$0
HIPAA EFT and Remittance Advice 25%	\$24,000	\$6,000	\$0	\$0
<b>Total Dental FI (Delta)</b>	<b>\$939,000</b>	<b>\$234,750</b>	<b>\$340,000</b>	<b>\$85,00</b>
<b>HCO</b>				
NPI (CR)	\$0	\$0	\$0	\$0
<b>Total HCO FI (Maximus)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Total HIPAA</b>	<b>\$21,699,535</b>	<b>\$3,935,354</b>	<b>\$22,499,346</b>	<b>\$2,716,527</b>

Does not include HIPAA support costs or FFP for other departments' HIPAA costs, which are budgeted in the Other Administration tab of the Estimate.

**MEDI-CAL ASSUMPTIONS**  
**November 2013**  
**FISCAL YEARS 2013-14 & 2014-15**

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**INTRODUCTION**

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction, and is derived from a 36-month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the

future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Estimate.

*Note: A list of acronyms and abbreviations has been provided following the Assumptions Section.*

## FEE-FOR-SERVICE BASE ESTIMATES

The FFS base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and \$/claim or \$/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

	USERS	= f(TND, S.DUM, O.DUM, Eligibles)
	CLAIMS/USER	= f(TND, S.DUM, O.DUM)
	\$/CLAIM	= f(TND, S.DUM, O.DUM)
WHERE:	USERS	= Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	= Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\$/CLAIM	= Total monthly \$ divided by total monthly claims or units by service and aid category.
	TND	= Linear trend variable.
	S.DUM	= Seasonally adjusting dummy variable.
	O.DUM	= Other dummy variable (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.)
	Eligibles	= Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, claims/user and \$/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

**ELIGIBILITY: NEW ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
E 0.1	(PC-10)	X	<p><u>County Health Initiative Matching Program</u></p> <p>Pursuant to Assembly Bill (AB) 495 (Chapter 648, Statutes of 2001), the County Health Initiative Matching (CHIM) Program was enacted and began operations in April 2004. The Managed Risk Medical Insurance Board (MRMIB), via contracts with three counties (San Francisco, San Mateo and Santa Clara) operates CHIM. This program provides health coverage for eligible children up to age 19 in families with incomes between 250 and 400 percent of the federal poverty level that are not eligible for Medi-Cal or the Healthy Families Program. Coverage is provided through county-sponsored insurance programs, which provide comprehensive benefits similar to the Healthy Families Program. Program costs are funded by matching county expenditures with Title XXI federal funds in participating counties that have been approved by the federal government. MRMIB manages the transfer of federal funds, and the counties administer the program. Pursuant to AB 1494 (Chapter 28, Statutes of 2012), effective January 1, 2013, children with incomes at or below 250 percent of the federal poverty level in the HFP began transitioning into Medi-Cal through a phase-in methodology. Additionally beginning November 2013, infants born to mothers in the Access for Infants and Mothers (AIM) Program will begin transitioning into the Medi-Cal delivery system through a phase-in methodology. Given these transitions of children's coverage from MRMIB to DHCS, and implementation of health care reform, beginning January 1, 2014, DHCS will be vested with the duties of MRMIB in carrying out the activities of CHIM. Due to the maintenance of effort (MOE) requirements of ACA, if an applicant county elects to cease funding the nonfederal share, state general fund shall be provided until the MOE obligation is no longer applicable.</p>
E 0.2	(CA-12)	X	<p><u>Reduction of CNI-Based COLA to Counties</u></p> <p>The cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated for FY 2014-15.</p>

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"PC" refers to "Policy Change".

"PC-1" means the fiscal impact of this assumption is in Policy Change 1.

"PC-BA" indicates the fiscal impact is a base adjustment or other part of the base.

"PC-CA" means there is a fiscal impact on County Administration.

"PC-OA" means there is a fiscal impact on Other Administration.

"PC-NA" means there is no fiscal impact or that the fiscal impact is unknown.

**ELIGIBILITY: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
E 0.3 (PC-212)	X	<u>AIM Linked Mothers 200-300% FPL</u>
		Effective July 1, 2014, Access for Infants and Mothers (AIM) linked mothers with incomes between 200-300% of the federal poverty level (FPL) will begin transitioning into the Medi-Cal delivery system. Mothers 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.
		The AIM linked mothers program is funded with Cigarette and Tobacco Surtax Revenues (Proposition 99), subscriber fees, and eligible Title XXI funding.

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		C/Y	B/Y	
E 1	(OA-10) (OA-69)	X	✗	<p><u>Single Point of Entry</u></p> <p>The Department and the Managed Risk Medical Insurance Board (MRMIB) developed an application form for the Healthy Families Program (HFP), which is also used as a screening tool for the Medi-Cal children's percent programs. Applicants send this form to the Single Point of Entry (SPE), where it is screened to determine whether it should be forwarded to a county welfare department (CWD) for a Medi-Cal determination for the children's percent programs or to MRMIB for a Healthy Families determination.</p> <p>The Department pays the federal Title XIX and the federal Title XXI share for the Medi-Cal applications through an interagency agreement with MRMIB. The Department will continue to pay the federal share for the Medi-Cal applications; however, the interagency agreement with MRMIB will be eliminated in early 2013 upon final execution of a DHCS contract with MAXIMUS. Effective January 1, 2013, all new applications submitted to SPE, whether paper or electronic, will be screened and forwarded to counties for a Medi-Cal determination. Effective January 1, 2013, the contract with the vendor for the HFP transition includes Single Point of Entry activities. <b><u>With the successful transition of all children from HFP to Medi-Cal, to the extent it is determined that it is an MOE violation to discontinue SPE, DHCS will explore options to continue the process.</u></b></p>
E 2	(PC-NA)	X	X	<p><u>Bridge to HFP</u></p> <p>This assumption has been moved to "Time Limited/No Longer Available" section.</p>
E 3	(PC-12)	X	X	<p><u>Resource Disregard – % Program Children</u></p> <p>Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits. Enhanced federal funding is available through State Children's Health Insurance Program (SCHIP).</p>
E 4	(PC-11)	X	X	<p><u>New Qualified Immigrants</u></p> <p>The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as amended, specifies that federal funding is not available for full-scope Medi-Cal services for most Qualified Nonexempt Immigrants who enter the country on or after</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

August 22, 1996, for the first five years they are in the country. Most New Qualified Immigrants are only eligible for FFP for emergency services and pregnancy-related services. California is continuing to provide full-scope Medi-Cal services to immigrants who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Immigrants is identified through a retroactive tracking system and the federal government is reimbursed on a retroactive basis for the FFP paid that is not available for these services.

~~PRWORA requires deeming an alien's sponsor's income and resources for Medicaid. The Department is awaiting guidance from CMS to determine if FFP is available for services provided to Newly Qualified Aliens who have been in the country for five years and after the federal sponsored alien rules are applied. The Department will continue to claim FFP for nonemergency services for sponsored persons who have been here for more than five years until those instructions are issued.~~

E 5    (PC-8)    X        X        Refugees

The federal Refugee Act of 1980 provides states with 100% of a State's Medicaid cost of services to Refugee Cash Assistance and Refugee Medical Assistance programs for up to eight months from the date of arrival in the United States, date of final grant of asylum, and date of certification for trafficking victims.

The California Department of Public Health (CDPH) administers California's Refugee Resettlement Program federal grant and the Department invoices CDPH for the reimbursement of the Medical Assistance Program expenditures.

E 6    (OA-29)    X        X        SSA Costs for Health Coverage Information

The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for SSI/SSP recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.

E 7    (OA-12)    X        X        Postage & Printing

Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries. Beginning in October 2008, the design, translation, focus testing and printing of certain informing and application forms and the mailing to beneficiaries or distribution to community based organizations and counties are performed by the Health Care Options vendor. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees, and at least every 3 years to existing beneficiaries and within 60 days of a material revision to the notice to current enrollees. Additionally, every 3 years, current enrollees must be notified of the availability of the notice and how to obtain the notice. Postage and printing costs for the HIPAA NPP are included in this item.

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.

E 8    (CA-11)    X        X        Systematic Alien Verification Entitlement System

The federally mandated Systematic Alien Verification Entitlement (SAVE) system was implemented in California on October 1, 1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing Income and Eligibility Verification System to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.

E 9    (OA-64)    X        X        Maternal and Child Health-CDPH

Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women, infants, children, and adolescents: (1) reduction of high

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

death rate for African-American infants; (2) case management and follow-up services for improving access to early obstetrical care for pregnant women; (3) recruitment and technical assistance for providers under the Comprehensive Perinatal Services Program; (4) general maternal and child health scope of work local program activities, including perinatal education, services and referral; and (5) case management for pregnant teens, education and prevention of subsequent pregnancies. Effective July 1, 2009, all GF was eliminated from the Maternal and Child Health programs. Local agencies continue to match Title XIX funds with Certified Public Expenditures.

E 10 (PC-NA) X X

Outreach – Children

This policy change has been moved to Discontinued Assumptions-Time Limited.

E 11 (CA-2) X X

Statewide Automated Welfare Systems

The Statewide Automated Welfare Systems (SAWS) consist of three county consortium systems: the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER), the Consortium-IV (C-IV) and the CalWORKs Information Network (CalWIN).

The SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

The LEADER is the automated system for Los Angeles County and it is currently in the maintenance and operation phase. The County began the process to replace the LEADER system and has completed contract negotiations with the successful bidder (Accenture). Federal oversight agencies, OSI, and the County board of supervisors have reviewed and approved the LEADER Replacement System (LRS) development contract. Development began in November 2012. While the replacement system is being developed, the County received state and federal approval to extend the existing LEADER maintenance and operations contract, through April 2015.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The CalWIN consortium and C-IV system are in the maintenance and operation phase.

The State and the counties in the current LEADER and C-IV consortia are working together to develop a new consortium.

E 12 (CA-4)    X    X

CalWORKs Applications

Beginning in 1998 a portion of the costs for CalWORKs applications can be charged to Medi-Cal. CDSS has amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal eligibility to be shared between the two programs.

E 13 (PC-6)    X    X  
 (PC-FI)

CHDP Gateway

In order to help ensure that all children have access to medical care, the CHDP Gateway program was implemented July 1, 2003. Through this program, children receiving a CHDP screen are pre-enrolled in Medi Cal/Healthy Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal/Healthy Families coverage. To facilitate this application, each child for whom the family indicates a desire for continuing Medi-Cal/Healthy Families coverage is sent a CHDP cover letter and a Medi-Cal/Healthy Families application form that is used to screen for the Medi-Cal children's percent programs. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in Medi-Cal threshold languages. The Healthy Families application is returned to the Single Point of Entry (SPE) and is screened for the Medi-Cal children's percent programs and forwarded to the county for a Medi-Cal determination or to Healthy Families.

The state-funded CHDP Program continues to provide screens to children eligible for limited-scope Medi-Cal. Effective October 1, 2003, the federal share of funding for the pre-enrollment costs is Title XXI funds, as required by federal statute. Funding ratios are 65% FFP/35% GF for children with income between Medi-Cal limits and 250% of poverty. For children with income below Medi-Cal limits, the sharing ratio is 50% FFP/50% GF.

Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment,

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

so claims are no longer Title XXI funded. Children screened to HFP continue to be claimed under Title XXI.

Medi-Cal receives funding from the Childhood Lead Poisoning Prevention (CLPP) Fund to cover blood lead testing as part of the CHDP Health Assessment for young children with risk factors for lead poisoning.

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. All children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal. DHCS will continue to receive enhanced Title XXI funding for these children.

Effective January 1, 2013, funding for aid code 8X shifted from SCHIP to Medicaid Children’s Health Insurance Program (MCHIP).

**Effective January 1, 2013, children receiving a CHDP screen are pre-enrolled in Medi-Cal for Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal for Families coverage. Each child, for whom the family indicates a desire for continuing Medi-Cal coverage, is sent a CHDP cover letter and a Medi-Cal for Families application form that is used to screen for the Medi-Cal children’s percent programs.**

E 14 (OA-77) X X

Merit System Services for Counties

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi Cal staff in 30 County Welfare Departments (CWD) and oversight in the other 28 counties.

E 15 (CA-6) X X  
 (CA-9)

County Cost of Doing Business

Based on the Medi-Cal County Administration Cost Control Plan, county welfare department administrative cost increases for Medi-Cal eligibility determinations are limited to a maximum increase of the California Necessities Index (CNI) as calculated by the

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				Department of Finance, or state employee salary increases, whichever is greater.
E 16	(CA-7)	X	X	<u>Los Angeles County Hospital Intakes</u>  Los Angeles County uses Patient Financial Services Workers (PFSWs) to provide intake services for Medi-Cal applications taken in Los Angeles County hospitals. Welfare & Institutions (W&I) Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services (DPSS) eligibility workers. The federal share for any costs not covered by the DPSS rate is passed through to the county.
E 17	(CA-NA)		X	<u>Eligible Growth</u>  The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases. Eligible growth <del>will not be</del> <b>was not</b> funded in FY 2013-14 <b><u>and will not be funded in FY 2014-2015.</u></b>
E 18	(OA-66)	X	X	<u>Department of Social Services Administrative Costs</u>  The Department provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS), via interagency agreements (IAs), for the administrative costs related to services provided to Medi-Cal beneficiaries under: <ul style="list-style-type: none"> <li>• In-Home Supportive Services (IHSS) <b><u>programs (which include Community First Choice Option, Personal Care Services Program and the IHSS Plus Option).</u></b></li> <li>• Child Welfare Services/Case Management System (CWS/CMS), <b><u>and</u></b> the</li> <li>• Statewide Automated Welfare System (SAWS).</li> </ul>
E 19	(PC-17) (PC-15) (PC-16)	X	X	<u>Public Assistance Reporting Information System (PARIS)</u>  PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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 beneficiary information with other states to identify changes in residence and public assistance benefits in other states.

E 20 (CA-13) X X

County Administration Reconciliation

Within two years following the end of a fiscal year, county administrative expenditures are reconciled to the county administration allocation for the applicable fiscal year. In FY ~~2012-13~~ **2013-14**, the Department ~~completed~~ **plans to complete** the final reconciliation for FY ~~2010-11~~ **2011-12** and the ~~an~~ interim reconciliation for FY ~~2011-12~~ **2012-13**. ~~In FY 2013-14, the Department plans to complete an interim reconciliation for FY 2012-13.~~ **In FY 2014-15, the Department plans to do a final reconciliation for FY 2012-13.**

E 21 (OA-56) X X

Q5i Automated Data System Acquisition

The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance, and support. The Q5i system is used to support quality control efforts for the following state and federally mandated programs: Medi-Cal Eligibility Quality Control, County Performance Standards, Payment Error Rate Measurement, and Anti-Fraud/Program Integrity.

E 22 (OA-21) X X

Medi-Cal Eligibility Data System (MEDS)

MEDS is currently the only statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Funding is required for MEDS master Client Index maintenance, data matches from various federal and state agencies, SSI termination process support, Medi-Cal application alerts, MMA Part D buy-in process improvements, eligibility renewal process, and reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities. Costs currently are offset by reimbursements made from other state departments using MEDS.

In addition, maintenance funding is required for the Business Objects (BO) software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.

**MEDS will include supporting the Advance Premium Tax Credit (APTC) and Cost Share Reduction (CSR) programs after January 2014. The MEDS system will develop unique identifiers for the new population.**

E 23 (OA-75)    X    X

Veterans Benefits

AB 1807 (Chapter 1424, Statutes of 1987) permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the Department of Veterans Affairs.

E 24 (PC-13)    X    X

CHIPRA – Full-Scope Medi-Cal for New Qualified and Lawfully Present Immigrant Children and Pregnant Women

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the U.S. for less than five years (referred to as New Qualified Immigrants) and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services.) CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children under the age of 21 or pregnant women even if they have been in the U.S. for less than five

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

years. CHIPRA also gives states the option to provide full-scope Medi-Cal with FFP to eligible immigrants who are lawfully residing children under the age of 21 or pregnant women (including some lawfully present immigrants who are not Qualified Aliens). The Department received federal approval of State Plan Amendment (SPA) 09-14 on April 1, 2009 which authorizes the state to implement both of these options. **A new SPA, required for implementation of the Affordable Care Act, will revise the definition of lawful presence for purposes of providing full scope Medi-Cal to pregnant women and children who are lawfully present. Those changes are not expected to impact the cost of this coverage.**

E 25 (PC-5)    X    X  
 (PC-7)  
 (OA-39)

**Medi-Cal Inpatient Services for Inmates**

AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department, counties, and the California Department of Corrections and Rehabilitation (CDCR) to claim federal reimbursement for inpatient hospital services for Medi-Cal eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Effective April 1, 2011, the Department began accepting Medi-Cal applications from the California Correctional Health Care Services (CCHCS) for eligibility determinations for State inmates. Claims will be processed retroactive to November 1, 2010. The Department will budget the FFP for services and CDCR administrative costs and CDCR will continue to budget the GF. Previously these services were paid by CDCR with 100% GF. Additionally, the Department is taking steps to implement Medi-Cal coverage of inpatient hospital services provided off the grounds of the correctional facility for eligible county inmates.

AB 396 (Chapter 394, Statutes of 2011) authorized the Department and counties to claim federal reimbursement for inpatient hospital services and inpatient psychiatric services for 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.

SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to grant medical parole to permanently medically incapacitated state inmates. A State inmate granted medical parole is potentially eligible for Medi-Cal. When an inmate is granted medical parole, CDCR submits a Medi-Cal application to

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

the Department to determine eligibility. Previously these services were funded through CDCR with 100% GF.

SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or designee, to request the resentencing of certain prisoners from a county correctional facility to medical probation or compassionate release. Resentencing is available as long as the prisoner does not pose a threat to public safety, has a life expectancy of six months or less, is physically incapacitated, or needs long term care. Prior to compassionate release or medical probation, a placement option must be secured. Also, the county must examine the prisoner's eligibility for Medi-Cal or other medical coverage to assist in funding the prisoner's medical treatment while on medical probation or compassionate release. Counties are required to pay the non-federal share of Medi-Cal expenditures associated with the bill's implementation for the period of time the offender would have otherwise been incarcerated. **The department is developing the FFP claiming requirements for these county inmate claims and expects to be able to begin processing those claims in January 2014.**

E 26 (PC-NA) X X

Lomeli, et al., v. Shewry

This policy change has been moved to Discontinued Assumptions-Time Limited.

E 27 (PC-1) X X  
 (PC-75)  
 (PC-FI)  
 (OA-10)  
 (CA-5)  
 (PC-73)

Transition of Healthy Families Children to Medi-Cal

**Pursuant to** AB 1494 (Chapter 28, Statutes of 2012) requires, effective January 1, 2013, children subscribed in the HFP **began transitioned transitioning** into Medi-Cal through a phase-in methodology. Coverage of this population under Medicaid programs is permissible pursuant to the federal Social Security Act to provide full scope Medi-Cal benefits to such eligible children who are optional targeted low-income children with family incomes up to and including 200% of the federal poverty level (FPL).

Assets will be exempt for these children and an income disregard will be available creating an effective income level not to exceed 250% of the FPL. Individuals with incomes above 150% and up to 250% of the FPL will be subject to premiums at the same level of the Community Provider Plan (CPP) option as used under the HFP. Children with incomes at and below 150% of the FPL will not pay premiums.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

In pursuing this option to cover these targeted low income children, the benefits and administrative costs provided to these children are eligible for enhanced federal funding of 65% FFP / 35% GF under Title XXI. To the extent possible, the children will be mandatorily enrolled into Medi-Cal managed care delivery systems; and to the extent such delivery models are not available, benefits will be provided under Medi-Cal fee-for-service arrangements. Implementation is contingent upon receiving necessary federal approvals.

**In November 2012, The the Department has provided began mailing** written notices to beneficiaries enrolled in Healthy Families describing **HFP explaining** their transition to the Medi-Cal **Managed Care** program and changes to anticipate prior to their movement into Medi-Cal. **The mailings will continue throughout 2013. They include information notices, frequently asked questions, reminder notices, confirmation letters, and choice packets.**

Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) beneficiaries are carved out and provided by county mental health departments. Specialty mental health services for HFP SED beneficiaries transferred into the Medi-Cal program who meet medical necessity criteria for Medi-Cal specialty mental health services will continue to be provided through county mental health departments. County mental health departments are eligible to claim FFP through the CPE process.

E 28 (PC-9) X X **Maternal and Child Health Access (MCHA) vs. DHCS and MRMIB**

The Department uses the Single Point of Entry (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. MCHA contends that the Department and Managed Risk Medical Insurance Board (MRMIB) are required to use the joint application as an application for all Medi-Cal programs, not just the FPL program, as is the current practice. In addition, MCHA raised several other issues relating to the administration of SPE, including notice requirements and infant eligibility.

On December 6, 2010, the court issued its decision ruling in favor of the Department on all issues except that for children ages 6-18 the State must screen for section 1931(b) Medi-Cal before

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

enrolling the child in HFP. Most significantly, the court upheld the Department's current practice of using the joint application as a screen for only one Medi-Cal program and the ruling did not change the current screening for the FPL Medi-Cal program.

On July 10, 2012, San Francisco Superior Court issued an order enforcing writ requiring that, by August 31, 2012, the SPE conduct the 1931(b) Medi-Cal program screen using the current application for children age 6 up to age 19 before enrolling a child in the HFP. The Department previously had agreed to implement a screen at SPE to identify "deemed eligible" infants. These requirements will result in an increase in caseload duties for county eligibility workers and additional benefit costs. Effective January 1, 2013, the HFP subscribers began transitioning into Medi-Cal through a phase-in methodology **to be completed in calendar year 2013.** Additionally, the new screening process was implemented, and all applications submitted to SPE are sent to county eligibility workers for a Medi-Cal determination. **Effective January 1, 2014, a new single streamlined application will be used.** Petitioners have applied for an award **and were awarded payment** of attorneys' fees, **which the Department paid in FY 2012-13.**

E 29 (PC-14) X X

Incarceration Verification Program

The Department is improving the process to identify individuals ineligible for Medi-Cal full and limited scope 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.

E 30 (OA-42) X X

Vital Records Data

The Department previously received vital records data from California Department of Public Health (CDPH) in a case-by-case basis. To improve efficiency, the Department decided to establish automated and timely processes to receive data from CDPH on a regular basis.

E 31 (PC-4) X X

AIM Linked Infants 250-300% FPL

Effective ~~October~~ **November** 1, 2013, Access for Infants and Mothers (AIM) Linked Infants will begin transitioning into the Medi-

**ELIGIBILITY: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

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.

**E 32** **(PC-29)** **X**  
**(CA-8)****State-Only Former Foster Care Program**

**AB 82 (Chapter 23, Statutes of 2013) extends Medi-Cal benefits to all former foster care youth who turn 21 years old between Jul 1, 2013 and December 31, 2013. Without this extension, they otherwise would have lost coverage. Costs for the extension of coverage will be 100% State funded.**

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## AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA will establish a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the current practice of using various income disregards to adjust family income will be replaced with a single 5% income disregard. The ACA will also simplify the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons will not change.

The new standard will allow current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

In addition, the ACA will impose a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled, in Medi-Cal to enroll in the program. The Department expects this expansion group, ~~to the extent the State chooses to exercise this option,~~ and the currently eligible but not enrolled population to result in a significant number of new Medi-Cal beneficiaries.

For those newly eligible adults in the expansion group, the ACA will provide California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled, in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA will increase the CHIP FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

The ACA requires the Department to establish a benefit package, called a benchmark plan, for the expansion population. CMS has not released the final rules that will govern the benchmark plan and, consequently, it is unknown what type of benchmark plan California will choose to offer.

## AFFORDABLE CARE ACT: NEW ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
ACA 0.1 (PC-27)	X	X	<p><u>USPSTF Grade A and B Recommendations</u></p> <p>Effective January 1, 2013, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% in FMAP for providing United States Preventative Services Task Force (USPSTF) recommended grade A or B preventive services and adult vaccines. Eligible preventive services must be part of the standard Medicaid benefit package and states cannot impose copayments for these services. The State provides these preventive services within the existing standard benefit package with no imposed cost sharing. To stay current with the most recent recommendations, the Department will update its coverage and billing codes to comply with recommendations made by the USPSTF.</p>
ACA 0.2 (PC-25) (OA-26)	X	X	<p><u>ACA Expansion – Presumptive Eligibility by Hospitals</u></p> <p>The ACA requires the Department to give hospitals the option, as of January 1, 2014, to determine presumptive eligibility for Medicaid. A qualified hospital may elect to make presumptive eligibility determinations on the basis of preliminary information and according to policies and procedures established by the Department. The Department will permit presumptive eligibility under this provision for:</p> <ul style="list-style-type: none"> <li>• Pregnant women;</li> <li>• Infants and children under the age of 19;</li> <li>• Parents and other caretaker relatives;</li> <li>• Childless adults 19-64; and,</li> <li>• Former foster care youth.</li> </ul> <p>The State anticipates that many of the eligible hospitals will participate. This requires the development of a simplified application form, online application and systems interfaces with MEDS or a manual process for county eligibility workers.</p>
ACA 0.3 (PC 205)	X	X	<p><u>Health Insurer Fee</u></p> <p>The ACA requires a Health Insurer Fee to be levied on all non-exempt insurers. The fee will be effective January 1, 2014, and will be collected by the federal government in September 2014. The Department will pay increased capitation rates to Medi-Cal Managed Care plans to fund the Health Insurer Fee.</p>

## AFFORDABLE CARE ACT: NEW ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
ACA 0.4 (PC 206)	X	X	<p><u>ACA Express Lane Enrollment</u></p> <p>The Centers for Medicare and Medicaid has provided several options to facilitate enrollment into the Medicaid programs. These options are designed to alleviate the influx of applications under the ACA by providing Medicaid eligibility to certain groups without conducting a separate Medicaid eligibility determination. SBx1 1 (Chapter 4, Statutes of 2013) requires the Department to seek the necessary federal waivers to implement two of these options. The targeted groups that would be provided Express Lane Enrollment into Medi-Cal are:</p> <ul style="list-style-type: none"> <li>• CalFresh adult and children eligibles; and</li> <li>• Parents/caretaker relatives of Medi-Cal income eligible children.</li> </ul>
ACA 0.5 (CA-14)	X	X	<p><u>Enhanced Federal Funding</u></p> <p>As part of guidance related to implementation of the ACA, the Centers for Medicare and Medicaid Services (CMS) has published guidance concerning federal funding for eligibility determination functions. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced 75% federal funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.</p>

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
ACA 1 (PC-19)	X	X	<p><u>Payments to Primary Care Physicians</u></p> <p>The ACA requires Medi-Cal to increase 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 that were in effect as of July 1, 2009 to the Medicare level for primary care services. <b><u>CMS approved SPA 13-003 in October 2013.</u></b></p>
ACA 2 (PC-34)	X	X	<p><u>Managed Care Drug Rebates</u></p> <p>The ACA extended the federal drug rebate requirement to Medicaid managed care outpatient covered drugs. In addition to County Organized Health Systems, Medi-Cal drug rebates are now also provided by:</p> <ul style="list-style-type: none"> <li>• Geographic Managed Care (GMC) health plans</li> <li>• Two-Plan model health plans, and the</li> <li>• Health Plan of San Mateo (HPSM), a County Organized Health System (COHS).</li> </ul> <p>Previously, only COHS health plans except for HPSM were subject to the rebate requirement.</p> <p>The Department will invoice for these rebates, retroactive to March 23, 2010, beginning in March 2013.</p>
ACA 3 (PC-NA)	X		<p><u>Federal Drug Rebate Change</u></p> <p>This assumption has been incorporated into the Federal Drug Rebate assumption.</p>
ACA 4 (OA-8)	X	X	<p><u>CalHEERS Development</u></p> <p>The ACA mandates the establishment of health insurance exchanges, in California, known as <del>the Health Benefit Exchange (HBEX)</del> <b><u>Covered California</u></b> to provide competitive health care coverage for individuals and small employers. As required by ACA, States must establish the ability to accept online application and to determine an applicant's eligibility for subsidized coverage. States are also required to use a single, streamlined application to apply for all applicable health subsidy programs. The application</p>

**AFFORDABLE CARE ACT: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

may be filed online, in person, by mail, by telephone, or with the Medicaid and Children’s Health Insurance Program (CHIP) agency. To meet this requirement, the Department and the Exchange have formed a partnership to acquire a Systems Integrator to design and implement the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) as the business solution.

ACA also offers new enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required Exchanges.

ACA 5 (OA-34) X    X  
(OA-40)

MEDS Interface with CalHEERS

CalHEERS will be programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through Covered California, Medi-Cal and the Healthy Families program. In order to provide seamless integration with the new CalHEERS system, the Department will establish and design the implementation of technology solutions for ongoing maintenance of Medi-Cal Eligibility Data System (MEDS) changes and integration with CalHEERS.

The Department will receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related systems changes needed to interface with CalHEERS.

The Department hired contractors to conduct a feasibility study and develop a federal Advanced Planning Document (APD) to modernize MEDS. The Department plans to finalize and send CMS the APD to obtain approval for the MEDS modernization procurement by the end of FY 2012-13 project in FY 2013-14. The Department anticipates hiring contractors to assist with:

- The writing of the Request for Proposal (RFP),
- Procurement,
- Design,
- Development, and
- Implementation.

The MEDS modernization will transition MEDS from a stand-alone legacy system to a modernized, integrated solution that addresses the requirements of the ACA, and increases the Department’s

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

			alignment with the federal Medicaid Information Technology Architecture (MITA). <b><u>The Department anticipates that the MEDS Modernization project will start in July 2014 and continue through June 2020.</u></b>
ACA 6 (OA-28)	X	X	<p><u>Prevention of Chronic Disease Grant Project</u></p> <p>Section 4108 of the ACA authorizes the five-year Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project. The Department was awarded 100% federal funds to implement the Medi-Cal Incentives to Quit Smoking Project. This project will use outreach and incentives to encourage access to smoking cessation services for Medi-Cal beneficiaries. The Department has established an Interagency Agreement with UCSF for the administration, implementation, and evaluation of the MIPCD project.</p>
ACA 7 (PC-20)	X	X	<p><u>Community First Choice Option</u></p> <p>Section 2401 of the ACA establishes a new State Plan option to provide home and community-based attendant services and supports. These services and supports may be offered through the federal Community First Choice Option (CFCO). The CFCO, which was available commencing October 1, 2010, allows States to receive a 6% increase in federal match for expenditures related to this option.</p> <p>On December 1, 2011, the Department and CDSS submitted a SPA proposing to transition eligible participants in the Personal Care Services and In-Home Supportive Services Plus Option programs into CFCO. The SPA, approved on September 4, 2012, allows additional Title XIX funds to be available under CFCO retroactively to December 1, 2011.</p> <p>On May 7, 2012, CMS released the final regulation requiring that to be eligible to receive CFC services; individuals must meet the following requirements:</p> <ul style="list-style-type: none"> <li>• An institutional level of care furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded,</li> <li>• An institution providing psychiatric services for individuals under 21, or</li> <li>• An institution for mental diseases for individuals age 65 or over.</li> </ul>

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

Since California submitted its SPA prior to the publication of the final regulation, CMS will provide the State with a transitional period of one year from the effective date of the CFC final regulation to comply with the eligibility criteria in the final regulation. This level of care criteria ~~will sunset~~ **expired on** July 6, 2013. Thus, the Department ~~must amend the~~ **submitted SPA 13-007 on May 3, 2013, with an** effective ~~July 6, 2013~~ date of July 1, 2013, to reflect updates to the State Plan that are in compliance with the final regulation.

ACA 8 (PC-FI) X	X	<p><u>Implementation of ACA Rules</u></p> <p>Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal program. The new rules establish additional requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.</p> <p>To <del>stay in</del> <b>work towards</b> compliance, the Dental FI needs to hire additional staff. Additional costs are expected to be incurred beginning in <del>March</del> <b>September</b> 2013.</p>
ACA 9 (PC-24) X (PC-148)	X	<p><u>Add-on for LTC (Non-AB 1629 &amp; AB 1629) Facilities</u></p> <p>Effective <del>2014</del> <b>2015</b>, under the Affordable Care Act, long-term care facilities which elect to provide health insurance for employees, and are not currently doing so, will experience additional costs to provide health coverage. An add-on to the rates to reimburse the facilities for the additional costs will be effective <del>2014</del> <b>2015</b>.</p>
ACA 10 (PC-31) X (OA-57)	X	<p><u>Recovery Audit Contractor</u></p> <p>SB 1529 (Chapter 797, Statutes of 2012) authorizes the Department to enter into contracts with one or more eligible Medicaid Recovery Audit Contractors (RACs) pursuant to section 6411(a) of the ACA. RACs' duties include reviewing post payment fee-for-service Medi-Cal claims, identifying improper payments, and educating providers. RACs are paid on a contingency basis based on the following terms:</p> <ul style="list-style-type: none"> <li>• 12.5% of amounts recovered after an identified overpayment, and</li> </ul>

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

- 10% of amounts refunded after an identified underpayment.

The Department does not assume any cost for the contract.

The Department awarded Health Management Systems, Inc. (HMS) the contract in April 2012 and ~~expects to approve~~ **approved** the final contract in FY 2012-13.

ACA 11 (PC-FI) X X

### HIPAA Operating Rules

The ACA includes provisions for Administrative Simplification, which builds on HIPAA with several new, expanded, or revised provisions. ACA requires the adoption of new HIPAA operating rules for eligibility and claim status transactions, effective January 1, 2013, along with Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions, effective January 1, 2014, as well as new standards for EFT and ERA. The Dental FI intends to make modifications to California Dental Medicaid Management Information System (CD-MMIS). The CA-MMIS FI intends to make modifications to California Medicaid Management Information System (CA-MMIS). Each FI plans to submit change orders, if necessary, to meet the new requirements. The Department is still working on the implementation of the operating rules for eligibility and claim status transactions. ACA requires the Department to adopt additional operating rules for the following by January 1, 2014:

- EFT transactions
- ERA transactions

The Department plans to submit APDs for each requirement, if necessary.

ACA 12 (PC-32) X X  
(PC-33)

### Disproportionate Share Hospital Reduction

The ACA requires the aggregate, nationwide reduction of State Disproportionate Share Hospital (DSH) allotments of \$500 million for FY 2013-14 **and \$600 million for FY 2014-15**. Reductions will increase for each fiscal year through FY 2019-20. The reduction for each state will be determined by CMS.

ACA 13 (OA-45) X X

### ETL Data Solution

The Centers for Medicare and Medicaid Services (CMS) is requesting data in a standardized format from the states, which

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

allows streamlining the review of system projects related to the Affordable Care Act (ACA). The Department plans to implement an enterprise-wide Extract, Transform, and Load (ETL) data solution to modernize and streamline the data transmission processes from the Department to the CMS' Transformed Statistical Information System (T-MSIS). The project provides modern capabilities to improve business processes; and the ability to collect comprehensive data regarding cost, quantity and quality of health care provided for Medi-Cal beneficiaries. The Department intends to procure a contractor to provide technical support for the design, development and implementation, and ongoing operation and maintenance of the ETL data solution.

ACA 14 (PC-21) X    X  
 (PC-28)  
 (OA-13)  
 (reworded)

### ACA Mandatory Expansion

Effective January 1, 2014, the ACA requires enrollment simplification for several current coverage groups and imposes a tax upon those without health coverage. These mandatory requirements will likely encourage many individuals who are currently eligible but not enrolled in Medi-Cal to enroll in the program. The expansion population will be eligible for full-scope Medi-Cal and a percentage will need substance use disorder treatment services and/or mental health services.

Enhanced FFP is not available for individuals who are currently eligible for Medi-Cal, but not enrolled.

ACA 15 (PC-30) X    X

### 1% FMAP Increase for Preventive Services

Effective January 1, ~~2014~~ **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 in receiving the enhanced FMAP, they must cover the specified preventive services in their standard Medicaid benefit package and cannot impose copayments for these services. California currently provides these preventive services within the standard benefit package and does not impose cost sharing on these services.

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y		
<u>C/Y</u>	<u>B/Y</u>	
ACA 16 (PC-23)	X	<p><u>ACA Expansion-CDCR Adult Inmates Inpatient Hospital Costs</u></p> <p>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.</p>
<u>ACA 17 (CA-3)</u>	X	<p><u>Implementation of ACA</u></p> <p><u>Effective October 1, 2013, open enrollment begins for Medi-Cal beneficiaries with the new ACA mandated rules. To establish eligibility and prepare for full implementation of ACA on January 1, 2014, the Department plans to provide additional funding to counties to:</u></p> <ul style="list-style-type: none"> <li>• <u>Make changes to existing county call centers;</u></li> <li>• <u>Create new county call centers;</u></li> <li>• <u>Hire additional staff needed to handle the expected increase in workload; and,</u></li> <li>• <u>Train new and existing staff on the new rules and system changes.</u></li> </ul>
<u>ACA 18 (PC-18)</u>	X	<p><u>ACA Optional Expansion</u></p> <p><u>Effective January 1, 2014, the ACA provides states with 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. The expansion population will be eligible for full-scope Medi-Cal and a percentage will need substance use disorder treatment services and/or mental health services.</u></p> <p><u>The ACA provides California with enhanced FFP for the newly eligible adults at the following rates:</u></p> <p><u>100% FFP from 2014 to 2016,</u>  <u>95% FFP in 2017,</u>  <u>94% FFP in 2018,</u>  <u>93% FFP in 2019,</u>  <u>90% FFP in 2020 and beyond.</u></p>
<u>(PC-26)</u>		
<u>(OA-13)</u>		
<u>(OA-9)</u>		

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

Effective January 1, 2014, a percentage of the newly eligible NQA population will shift into Covered California. The Department will cover all out-of-pocket expenditures and any benefit gaps that may occur from shifting into Covered California beginning April 2014.

A percentage of the ACA optional expansion newly eligible population will utilize LTSS benefits. The Department is seeking a waiver from the Centers of Medicaid Services (CMS) for retaining the current asset test for long-term care.

ACA 19 (PC-210) X

ACA Expansion-Pregnancy Only

Effective January 1, 2015, Medi-Cal eligibles who receive pregnancy-only services under the 200% of Federal Poverty eligibility program will have the option of receiving full-scope coverage through Covered California. Medi-Cal will cover the cost of Covered California premiums, out-of-pocket expenses, and services not provided by Covered California plans.

**BENEFITS: NEW ASSUMPTIONS**

	Applicable	F/Y	
	<u>C/Y</u>	<u>B/Y</u>	
B 0.1 (OA-59)		X	<p><u>Newborn Hearing Screening Program</u></p> <p>The Department plans to shift the NHSP Support Contract to the Local Assistance Budget. Currently, the funding for NHSP services are budgeted in the Medi-Cal and Family Health Local Assistance Appropriations and the contract services are budgeted in the State Support Appropriations.</p> <p>The NHSP inpatient and outpatient hearing screens, the diagnostic hearing evaluations, and medical interventions are budgeted in the Medi-Cal and Family Health Estimates.</p> <p>In the December 1997 Budget Change Proposal, State Support costs were identified for the Hearing Coordination Centers (HCC) and the Data Management Service (DMS). The HCCs provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who needs follow-up to assure they receive the needed services and referrals.</p> <p>The DMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The DMS also provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.</p>
B 0.2 (PC-51)	X	X	<p><u>Change Family PACT Program Benefits</u></p> <p>The Office of Family Planning conducts on-going monitoring and utilization management of the Family PACT program to evaluate the cost-effectiveness of services and identify opportunities to reduce program costs while maintaining the same quality of care. Effective November 1, 2013, the Department plans to:</p> <ul style="list-style-type: none"> <li>• Decrease over-utilization of emergency contraception,</li> <li>• Add clinic dispensing of ella® (emergency contraceptive)</li> <li>• Eliminate urine culture, and</li> <li>• Discontinue brand name anti-fungal drugs.</li> </ul> <p>Effective January 1, 2014, the Department plans to:</p>

**BENEFITS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

- Reduce chlamydia screening of women over 25 years of age, and
- Adopt a Medi-Cal Preferred List for oral contraceptives.

Under the Affordable Care Act, services for Family PACT are limited to medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting. Effective January 1, 2014, the Department plans to eliminate mammograms and pregnancy test only benefit to maintain compliance with Federal rules.

B 0.3 (PC-66) X X

Voluntary Inpatient Detoxification

Beginning January 1, 2014, SBX1 1 (Chapter 4, Statutes of 2013) provides for voluntary inpatient hospital detoxification services using methadone, non-narcotic drugs, or without medication. This service is included in the essential health benefits package adopted by the State. The service change affects the current Medi-Cal eligibles as well as the ACA mandatory and optional expansion population.

The Department will seek approval of a SPA to implement this new Medi-Cal service.

B 0.4 (PC-208) X X

Children's Dental Utilization

Centers for Medicare and Medicaid Services (CMS) have asked the Department to use comprehensive, coordinated treatment strategies to implement a risk-based disease prevention approach to childhood caries as a chronic disease (like asthma and diabetes). Current oral health guidelines say children should begin regular dental checkups on their first birthday or with their first tooth, the Department will identify beneficiaries ages 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. Early and proper oral health care should ultimately result in better oral health care outcomes and lower future more costly restorative services.

**BENEFITS: OLD ASSUMPTIONS**

B 1 (OA-65) X X

Health Care Program for Children in Foster Care

The Budget Act of 1999 included funds for the CDSS to establish a program utilizing foster care public health nurses in the child welfare program to help foster care children gain access to health-related services. The public health nurses are employed by the counties and funded through CDSS General Funds and Title XIX matching funds. The Department has an interagency agreement with CDSS.

On October 7, 2008, P.L. 110-352, the Fostering Connections to Success and Increasing Adoptions Act of 2008, was signed into law. P.L. 110-351 is an amendment to the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, and improve incentives for adoption. On January 1, 2010, the Department, through CDSS, implemented the new requirements to provide Health Oversight and Coordination.

The 2011 State/Local Program Realignment Initiative (Realignment) shifted the responsibilities for California child welfare system to the counties. Vehicle License Fund and Sales Tax revenues supplant the GF as the non-federal share. Due to concerns from state, federal, and local stakeholders that Realignment would effectively eliminate this program as a cohesive and effective statewide system, SB 1013 (Chapter 35, Statutes of 2012) provides continuing funding under the existing model to local Child Health and Disability Prevention programs. CDSS will redirect funds for this purpose from the newly established Local Revenue Fund of 2011. SB 1013 also requires this program to be realigned to local control once the Department obtains the federal approval for child welfare agencies to claim FFP. ~~CDSS anticipates that the transfer of the program to local control will occur by FY 2013-14.~~ **CDSS continues to work on a timeline that will transfer the Health Care Program for Children in Foster Care to local control.**

B 2 (PC-36) X X

Local Education Agency (LEA) Providers

Through the LEA Billing Option, LEAs can become Medi-Cal providers and submit claims for services to Medi-Cal beneficiaries within their jurisdiction. LEA providers may bill retroactively for services rendered up to one year prior to their date of enrollment as long as claims are billed within the statutory billing limit. LEAs claim FFP for specific services as authorized in W&I Code Section 14132.06. LEA providers are paid an interim rate based on pre-

**BENEFITS: OLD ASSUMPTIONS**

established billing allowances and audits are performed to reconcile actual costs with interim payments.

B 3 (PC-180) X X

Medi-Cal TCM Program

The Targeted Case Management (TCM) program provides funding to counties and chartered cities/local government agencies (LGAs) for assisting Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. Through rates established in the annual cost reports, local governments claim FFP for these case management services. TCM providers are paid an interim rate based on pre-established billing allowances and audits are performed to reconcile actual costs with interim payments.

B 4 (PC-179) X X

Targeted Case Management Services – CDDS

The Department provides Title XIX FFP for regional center case management services, as provided to eligible developmentally disabled clients via contract with the California Department of Developmental Services (CDDS) and authorized by the Lanterman Act. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible. FFP for Medi-Cal eligibles is authorized by a SPA.

B 5 (OA-1) X X  
(OA-7)

Medi-Cal Administrative Activities

AB 2377 (Chapter 147, Statutes of 1994) authorized the State to implement the Medi-Cal Administrative Claiming process. The Medi Cal program submits claims on behalf of local governmental agencies (LGAs) to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the Medi-Cal program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of Medi-Cal services.

Both LGAs and local educational "consortiums" (LECs) contract with the Department for reimbursement and may amend prior year contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when

**BENEFITS: OLD ASSUMPTIONS**

additional funds, such as special local initiatives and Proposition 10 fund spending determination of LGA status, are made available as the certified public expenditure.

SB 308 (Chapter 253, Statutes of 2003) redefines LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows these tribes to participate in the Medi-Cal Administrative Activities (MAA) program. CMS approved the California Tribal MAA Implementation Plan on January 9, 2009, which allows Tribal Entities and Tribal Organizations to participate in the MAA program by contracting with the State to receive reimbursement. On December 18, 2009, CMS approved reimbursement for non-emergency, non-medical transportation expenditures for Tribal entities.

The Department is currently working with CMS on an implementation plan for mental health plans to claim FFP for MAA.

B 6 (PC-49) X X

SCHIP Funding for Prenatal Care

In order to maximize federal funding, SB 77 (Chapter 38, Statutes of 2005), requires MRMIB to file a SPA in the CHIP to claim Title XXI 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care is currently 100% General Fund. Funding is being claimed for undocumented women, and for legal immigrants who have been in the country for less than five years. CMS approved the SPA in March 2006.

B 7 (OA-23) X X

Coordinated Care Management Pilot

The Budget Act of 2006 includes approval to establish and implement a Coordinated Care Management (CCM) Demonstration Project. The key elements of the CCM Project include maintaining access to medically necessary and appropriate services, improving health outcomes, and providing care in a more cost-effective manner for two populations enrolled in the fee-for-service Medi-Cal Program who are not on Medicare:

- CCMP-SPD (CCM-1): Seniors and persons with disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life. CCM-1 was completed with the mandatory enrollment of the SPD population into Medi-Cal managed care health plans;

**BENEFITS: OLD ASSUMPTIONS**

- CCMP-SMI (CCM-2): Persons with chronic health condition(s) and serious mental illnesses. The SMI portion ~~will expire~~ **expired** on July 31, 2013; and
- CBAS (CCM-2): This contract has been amended to include Adult Day Health Care (ADHC) services as the Department transitions eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit. The CBAS portion ~~will expire~~ **expired** on ~~August 31, 2014~~ **July 31, 2013**.

B 8	(PC-194)	X	X	<p><u>CLPP Funding for EPSDT Lead Screens</u></p> <p>Medi-Cal receives funding from the CLPP Fund to cover Early Periodic Screening, Diagnosis and Treatment (EPSDT) blood lead testing for beneficiaries with risk factors for lead poisoning. CLPP funding will be used for the non-federal share of the cost.</p>
B 9	(PC-NA)	X	X	<p><u>Physician and Clinic Seven Visits Soft Cap</u></p> <p>This assumption has been moved to the "Withdrawn" section.</p>
B 10	(PC-48)	X	X	<p><u>Hearing Aid Cap</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements a \$1,510 cap per beneficiary for hearing aid expenditures. 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 in nursing facilities or pregnant women.</p>
B 11	(PC-50)	X	X	<p><u>Copayment for Non-Emergency ER Visits</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of <b>up to</b> \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented <del>without exemptions</del> in the managed care setting. The hospital will collect the copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the copayment. AB 1467 (Chapter 23, Statutes of 2012) stipulates that for the purposes of Medi-Cal copayments, an emergency service is defined as the treatment of an emergency medical condition or services that result in an inpatient admission.</p>

**BENEFITS: OLD ASSUMPTIONS****The following are exempted:**

- **Pregnant women**
- **Children under 18 years old, or children in foster care**
- **American Indian/Alaskan Native**
- **Dual Eligible for Medicare and Medicaid**

**An amendment to the 1115 Bridge to Reform Waiver will be submitted to CMS. Approval is not anticipated until January 2014.**

B 12	(PC-182)	X	X	<p><u>EPSDT Screens</u></p> <p>The Child Health and Disability Prevention (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.</p>
B 13	(PC-184) (OA-72)	X	X	<p><u>CDDS Dental Services</u></p> <p>The Lanterman Act requires the California Department of Development Services (CDDS) to provide dental services to its clients. Because Medi-Cal no longer covers <del>most</del> <b>many</b> dental services for adults 21 years of age and older, CDDS has entered into an interagency agreement 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 processing claims and benefits will be reimbursed by CDDS. <b><u>With the restoration of select adult dental benefits to beneficiaries 21 years of age and older effective May 1, 2014 per AB 82 (Chapter 23, Statutes of 2013), costs will be adjusted appropriately.</u></b> Processing of CDDS claims started on January 12, 2012.</p>
B 14	(OA-74)	X	X	<p><u>Quitline Administrative Services</u></p> <p>Quitline provides a free telephone-based counseling program to help smokers quit. CMS is allowing the State to receive a 50% match of funds attributable to the administrative costs associated with Quitline providing services to Medicaid individuals. Since CDPH funds the helpline, the Department will claim the FFP and reimburse CDPH via an interagency agreement.</p>

**BENEFITS: OLD ASSUMPTIONS**

B 15 (PC-2) X X

Family PACT Program

Originally implemented as a state-only program in 1997, Family PACT became a Section 1115 demonstration project effective December 1, 1999. It provides family planning services to eligible, uninsured Californians with income at or below 200% of poverty. FFP at 90% has been assumed for most family planning services, testing for sexually transmitted infections (STIs), and sterilizations. The Federal Medical Assistance Percentage (FMAP) has been assumed for treatment of STIs and other family planning companion services. No FFP has been assumed for the treatment of some family planning-related medical conditions, including inpatient care for complications from family planning services. Costs for undocumented persons are assumed to be 13.95% of the Family PACT costs, as agreed upon by CMS, and are budgeted at 100% GF. Family PACT drugs will be included in the Medicaid Drug Rebate Program.

A State Plan Amendment (SPA), to replace the Family PACT waiver in accordance with the Federal Patient Protection and Affordable Care Act was approved on March 24, 2011. Under the SPA, effective retroactively to July 1, 2010, eligible family planning services and supplies formerly reimbursed with 100% General Funds will receive a 90% federal matching rate for certain eligible procedure codes, and family planning-related services will receive reimbursement at the State's regular FMAP rate.

Effective April 1, 2011, Medi-Cal allows retroactive eligibility for Family PACT qualifying clients for up to three months prior to the first day of the month of application to the Family PACT program.

B 16 (OA-27) X X

Family PACT Evaluation

An important component of the Family PACT Program is evaluating the effectiveness of the program. The University of California, San Francisco conducts the program evaluation. The evaluation includes, but is not limited to, analyzing access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.

~~A new contract to provide data, to monitor and evaluate the Family PACT program was negotiated for a five year term beginning July 1, 2010.~~

**BENEFITS: OLD ASSUMPTIONS**

~~The Department budgets the Title XIX federal Medicaid funds for the contract. The matching GF is budgeted in the CDPH budget in the FY 2012-13 Family PACT Evaluation policy change.~~

~~AB 1464 (Chapter 21, Statutes of 2012) transferred the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13 in the FY 2012-13 Family PACT Evaluation policy change.~~

B 17 (OA-32) X X  
(OA-78)

Family PACT Support, Provider Education and Client Outreach

The Family PACT Program has two main objectives. One is to increase access to services in targeted populations of adolescents, males, and medically underserved women **for low-income women and men, including adolescents**. The other is to increase the number of providers who serve these clients. Education and various support services are provided to Family PACT providers and potential providers, as well as clients and potential clients. The Office of Family Planning contracts with a variety of entities to provide these services.

~~A contract to provide Family PACT support, provider education, and outreach was negotiated for a three-year term beginning April 1, 2009. The Department has initiated a new procurement for these services.~~

~~The Department budgets the Title XIX federal Medicaid funds for these activities. The matching GF is budgeted in the CDPH budget for the FPACT Support, Provider Education & Client Outreach policy change.~~

~~AB 1464 (Chapter 21, Statutes of 2012) transferred the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13 in the Family PACT Program Administration policy change.~~

B 18 (PC-FI) X X

Family PACT Materials Distribution

An important component of the Family PACT Program is the distribution of client education materials to providers. The State, through the fiscal intermediary, has the responsibility to develop, print, purchase, and distribute over 125 different publications.

**BENEFITS: OLD ASSUMPTIONS**

B 19	(PC-FI)	X	X	<p><u>Family PACT Systems</u></p> <p>The establishment of the Family PACT Program required fiscal intermediary systems enhancements and modifications. The system changes have been made and are ongoing, as required for program maintenance.</p>
B 20	(OA-12)	X	X	<p><u>Family PACT HIPAA Privacy Practices Beneficiary Notification</u></p> <p>Under the federal HIPAA, it is a legal obligation of the Medi-Cal program to provide a Notice of Privacy Practices (NPP) to each Family PACT beneficiary explaining the rights of beneficiaries regarding the protected health information created and maintained by the program. Medi-Cal has an ongoing responsibility to provide this Notice to all new enrollees and to existing enrollees when a substantial change is made to the notice. Additionally, Medi-Cal must inform all beneficiaries about how to get a copy of this Notice at least every 3 years. Due to confidentiality concerns, distribution of the NPP to these beneficiaries is accomplished by distribution at the clinic. This assumption is to cover the cost of printing and mailing the NPPs to the clinics.</p>
B 21	(PC-47)	X	X	<p><u>Increased Federal Matching Funds for FPACT</u></p> <p>On March 24, 2011, CMS approved a State Plan Amendment (SPA) for the Family PACT Program, in accordance with the Federal Patient Protection and Affordable Care Act. 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 FMAP rate, effective retroactively to July 1, 2010.</p>
B 22	(PC-NA)	X	X	<p><u>Family PACT Retroactive Eligibility</u></p> <p>This assumption has been moved to the "Fully Incorporated into Base Data/Ongoing" section.</p>
B 23	(PC-42)	X	X	<p><u>Dense Breast Notification Supplemental Screening</u></p> <p>SB 1538 (Chapter 458, Statutes of 2012) would require health facilities administering mammograms to notify patients whose breasts are categorized as being heterogeneously or extremely dense and inform the 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</p>

**BENEFITS: OLD ASSUMPTIONS**

resonance imaging (MRIs) and ultrasounds. The provisions of this bill ~~will become~~ **became** operative April 1, 2013 and **will** sunset on January 1, 2019.

B 24 (PC-40) X X

**California Children's Services Program Pilots**

The Bridge to Reform (BTR), approved by CMS effective November 1, 2010, allows the Department to develop and implement four organized health care delivery systems to serve the California Children's Services (CCS) Medi-Cal eligible population in ~~at least four geographical locations within the State. The four organized health care delivery systems can use up to four models listed below for care delivery:~~ **The 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.

~~The Health Plan of San Mateo expects to begin operation in April 2013 and receive payments beginning in May 2013~~ **began operations effective April 1, 2013.** ~~The Department anticipates other geographical location plans to be implemented in FY 2013-14.~~

**B 25 (PC-38) X X**  
**(OA-24)**

**Restoration of Select Adult Dental Benefits**

**Effective May 1, 2014, AB 82 (Chapter 23, Statutes of 2013) restores select adult dental benefits to beneficiaries 21 years of age and older.**

**The following covered medical benefits will be restored:**

- **Examinations, radiographs/photographic images, prophylaxis, fluoride treatments,**
- **Amalgam and composite restorations,**
- **Stainless steel, resin, and resin window crowns,**
- **Anterior root canal therapy,**
- **Complete dentures, including immediate dentures, and**
- **Complete denture adjustments, repairs, and relines**

**The department will seek approval for federal financial participation and coverage of the above services.**

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## HOME AND COMMUNITY BASED SERVICES

### Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

### State Plan Benefits

#### In-Home Supportive Services (IHSS)

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must be age 65 years of age or older, disabled, or blind. Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)  
This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective ~~services~~ **supervision**.
2. IHSS Plus Option (IPO)  
This program provides personal care services but also allows the recipient of services to select ~~their provider, including family members~~ **a family member as a provider**.
3. Community First Choice Option (CFCO)  
This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

#### Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment;
- Development of an individualized service plan;
- Linkage and consultation;
- Assistance with accessing services;
- Crisis assistance planning;
- Periodic review.

## HOME AND COMMUNITY BASED SERVICES

### Waivers

Medi-Cal operates and administers various home and community-based services (HCBS) waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary state plan services are less than the total cost incurred at the otherwise appropriate nursing facility plus state plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS), Assisted Living (ALW), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with Developmental Disabilities, San Francisco Community Living Support Benefit (CLSB), and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

#### Assisted Living Waiver (ALW)

The ALW pays for assisted living, care coordination, community transition, translation/interpretation, and home modification in ~~seven~~ **ten** counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, ~~and San Bernardino,~~ **Alameda, Contra Costa, and San Diego**). Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE) or through a home health agency while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is ~~2,920 in 2012 and~~ 3,700 in 2013 **and 2014**. The waiver is approved from March 1, 2009 through February 28, 2014, **and is expected to be renewed for an additional five years**.

#### Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. A lawsuit was filed challenging elimination of ADHC (Darling et al. v. Douglas et al.), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver. Former ADHC participants and new eligible participants who meet the more stringent CBAS eligibility standards receive CBAS in approved CBAS centers. CBAS was provided through Medi-Cal FFS effective April 1, 2012 **and continues to be provided to eligible participants residing in non-managed care counties, or to eligible participants who are exempted from, or ineligible for enrollment in a managed care plan**. On July 1, 2012, CBAS transitioned into five County Organized Health System (COHS) managed care health plans. On October 1, 2012, CBAS transitioned into Two-Plan and GMC managed care plans, as well as one remaining COHS plan, Gold Coast Health Plan. Medi-Cal FFS continues to provide CBAS to eligible participants residing in non-managed care counties, or to eligible participants who are exempted from or ineligible for enrollment in a managed care plan. **As of October 1, 2012, CBAS was transitioned into all managed care health plans**. There is no cap on enrollment into this waiver service.

## HOME AND COMMUNITY BASED SERVICES

### In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed LOC. The waiver is approved from January 1, 2010 through December 31, 2014.

### Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver

Effective December 1, 2012, the Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver was merged with the Nursing Facility/Acute Hospital (NF/AH) Waiver, based on CMS approval. The newly merged waiver was renamed the Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver. Under the NF/AH – Transition and Diversion Waiver, current DD/CNC participants will continue receiving their existing services and the DD/CNC providers will continue to be reimbursed at the pre-existing DD/CNC daily per diem rates.

- ~~• The DD/CNC Waiver, served individuals with developmental disabilities, who are medically fragile and who otherwise would reside in subacute care facilities, acute care hospitals or in developmental centers. Services were provided specifically in DD/CNC residential homes that are licensed and enrolled in the Medi-Cal program as ICF/DD-Nursing Providers.~~
- The NF/AH waiver facilitates a safe and timely transition of Medi-Cal eligible beneficiaries from a medical facility to his/her home and community utilizing NF/AH Waiver services, and offers eligible Medi-Cal beneficiaries, who reside in the community, but are at risk of being institutionalized within the next 30 days, the option of utilizing the NF/AH Waiver services to develop a home program that will safely meet his/her medical care needs.

The NF/AH – Transition and Diversion Waiver provides Medi-Cal beneficiaries with long-term medical conditions, who met the acute hospital, adult, or pediatric subacute, nursing facility, distinct-part nursing facility (NF) Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization.

The waiver is approved from January 1, 2012 through December 31, 2016.

### San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements Assembly Bill 2968 (Chapter 830, Statutes of 2006) ~~and will allow~~ **which allows** the San Francisco Department of Public Health (**SFDPH**) to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. A person eligible for the CLSB Waiver must:

## HOME AND COMMUNITY BASED SERVICES

- Be a resident of the city and county of San Francisco;
- Be at least age 21 years or over;
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations;
- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting;
- Have one or more medical co-morbidities; and
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

CLSB Waiver community settings are limited to State-approved housing, which includes community care facilities licensed by the California Department of Social Services, Community Care Licensing, and Direct Access to Housing (DAH) sites operated by SFDPH.

CLSB Waiver services consist of Care Coordination, Enhanced Care Coordination, Community Living Support Benefit in licensed settings and DAH sites, Behavior Assessment and Planning, Environmental Accessibility Adaptations in DAH sites, and Home delivered meals in DAH sites.

~~Approved capacity of unduplicated recipients for this waiver is 221 for 2012, 377 for 2013, and 417 for 2014.~~ **The SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, a waiver amendment has been submitted to adjust enrollment estimates.** The waiver is approved from July 1, 2012 through June 30, 2017.

### Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

Services provided include:

- Case management;
- Skilled nursing;
- Attendant care;
- Psychotherapy;
- Home-delivered meals;
- Nutritional counseling;
- Nutritional supplements;
- Medical equipment and supplies;
- Minor physical adaptations to the home;
- Non-emergency medical transportation;
- Financial supplements for foster care.

## HOME AND COMMUNITY BASED SERVICES

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Approved capacity of unduplicated recipients for this waiver is 4,410 in 2013 and 4,490 in 2014. The waiver is approved from January 1, 2012 through January 31, 2016.

### Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with local agencies statewide to provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these ~~frail clients~~ **individuals**. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and be certified or certifiable for placement in a nursing facility. Services provided by MSSP include: adult day care / support center, housing assistance, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. Approved capacity of unduplicated recipients for this waiver is ~~16,335 in 2012 and~~ **13,080 for 2013 and 2014**. The waiver is approved from July 1, 2009 through June 30, 2014.

### Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)

The DD Waiver provides home and community-based services to developmentally disabled persons who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the mentally retarded (ICF/MR); in California, they are the Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. Approved capacity of unduplicated recipients for this waiver is ~~105,000 in 2012 and~~ 110,000 in 2013, **115,000 in 2014 and 120,000 in 2015**. The waiver is approved from October 1, 2011 through September 30, 2016.

### Pediatric Palliative Care (PPC) Waiver

The PPC provides children hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and Family Unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009 through March 31, 2012. The CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years

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## HOME AND COMMUNITY BASED SERVICES

effective April 1, 2012 through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800.

### **Managed Care Programs**

#### Program of All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical, long-term services and supports, dental, vision and other specialty services, allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities. Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place. The Department has statutory authority to contract with up to 15 PACE organizations.

#### SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease. The Department ~~will not renew the SCAN contract that ends December 31, 2013, and has notified SCAN in accordance with contract requirements~~ **has renewed the SCAN contract through December 31, 2014.**

### **Special Grant**

#### California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a Money Follows the Person Rebalancing Demonstration Grant, called the California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. Grant funds may be requested from January 1, 2007, through September 30, 2016. The grant requires the Department to develop and implement strategies for transitioning Medi-Cal beneficiaries who have resided continuously in health care facilities for three months or longer back to a federally-qualified residence.

**HOME & COMMUNITY BASED SERVICES:  
NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

H 1

### Home and Community-Based Services

Home and Community-Based Services (HCBS) are services designed to keep persons needing long-term care supported and safe in their homes or other community settings, in lieu of placing them in long-term care facilities like nursing homes, subacute or acute care hospitals, and intermediate care facilities for persons with developmental disabilities, or State Developmental Centers. HCBS also provide support for residents in long-term care facilities to return to their homes or communities.

HCBS encompass State Plan services, including Personal Care Services provided through the California Department of Social Services' In-Home Supportive Services program, **additional HCBS for Regional Center Clients**, and Adult Day Health Care; which was eliminated on March 31, 2012 and replaced by Community-Based Adult Services. Full risk managed care services are also provided through Programs of All-inclusive Care for the Elderly (PACE) and Senior Care Action Network (SCAN); an eight-year federal demonstration to transition long-term care facility residents back to their homes and communities. Several different waiver programs provide a range of services like private duty nursing, personal care, case management, habilitation, emergency response systems, respite, and home modifications for accessibility and safety.

(PC-174) X    X    A. Home and Community Based Services Waiver for Persons with Developmental Disabilities – CDDS

This waiver serves persons with developmental disabilities who are regional center clients and reside in community settings instead of intermediate care facilities for the developmentally disabled.

(PC-39) X    X    B. Multipurpose Senior Services Program – CDA  
(OA-70)

On June 23, 2009, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver for the period of July 1, 2009 through June 30, 2014. Under the waiver, the California Department of Aging (CDA) contracts with local government or nonprofit agencies to provide waiver services to individuals 65 years or older who are Medi-Cal eligible and who, in the absence of this waiver and as a matter of medical necessity, would

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

otherwise require care in a nursing facility. MSSP services include health care and personal care assistance, respite care, housing assistance, meal services, transportation, protective services, emergency response systems, and chore services.

The Department pays the MSSP claims. The GF is budgeted in the CDA budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay the MSSP claims.

No sooner than ~~September 1, 2013~~ **April 1, 2014**, in the counties participating in the CCI Duals Demonstration, managed care health plans will contract with existing MSSP sites for care management services consistent with the MSSP Waiver requirements.

H 2 (PC-NA) X X

### In-Home Operations Waiver

CMS approved the IHO Waiver renewal effective January 1, 2010 through December 31, 2014. The IHO Waiver “grandfathered in” Medi-Cal beneficiaries who were continuously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and continue to receive direct-care services primarily rendered by licensed nurses, and whose HCBS costs exceed the Level of Care (LOC) cost cap under the NF/AH Waiver. Each IHO participant’s LOC and waiver costs will remain the same as previously authorized.

H 3 (PC-181) X X

### Waiver Personal Care Services

AB 668 (Chapter 896, Statutes of 1998) requires Medi-Cal to add waiver personal care services (WPCS) to NF A/B and NF SA Levels of Care. This service is not available to those individuals at the Hospital LOC due to their extensive medical needs. WPCS is one option on the Menu of Health Services (MOHS) that NF/AH and IHO waiver participants may choose from, to the extent that waiver cost neutrality is assured.

H 4 (PC-171) X X  
(OA-61)

### Personal Care Services

In April 1993, the Medi-Cal program began covering personal care services as a benefit, making Title XIX funds available to the IHSS program under the administrative control of CDSS. Protective

**HOME & COMMUNITY BASED SERVICES:  
OLD ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

supervision and domestic and related services became IHSS-covered benefits effective August 1, 2004.

The State receives regular FMAP for provision services under the Personal Care Services Program and IHSS Plus Option, and 6% additional FMAP for provisions of Community First Choice Option services.

SB 1036 (Chapter 45, Statutes of 2012) requires mandatory enrollment of dual eligibles in eight counties into managed care for their Medi-Cal benefits, including their IHSS benefit. The transition will occur no sooner than ~~September 2013~~ **April 2014**. As this transition occurs, IHSS costs will be paid through managed care capitation. IHSS costs related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.

H 5 (PC-37) X X  
(PC-43)  
(PC-52)  
(OA-44)

California Community Transitions (CCT/MFP)

As required by CMS' awarded Money Follows the Person Rebalancing Demonstration Grant, CCT/MFP is developing and implementing strategies for transitioning Medi-Cal beneficiaries with long-term inpatient health facility stays back to community living. Through CCT/MFP, the Department receives enhanced FFP for demonstration pre-transition costs and federally-qualified HCBS provided during the first 365 days post transition. There are assumed Medi-Cal savings from transitioning institutionalized Medi-Cal beneficiaries back to the community with appropriate HCBS in place.

The Department established an Interagency Agreement (IA) with the California Department of Developmental Services (CDDS) to provide transition coordination services through its local Regional Centers. IAs with CDDS and the California Department of Social Services (CDSS) cover their provision of qualified HCBS to CCT/MFP transitioned Medi-Cal beneficiaries during the first 365 days post transition. The enhanced FFP received by the Department for these services is passed through to both CDDS and CDSS.

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
H 6	(OA-62)	X	X	<p><u>Health-Related Activities - CDSS</u></p> <p>Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.</p>
H 7	(OA-70)	X	X	<p><u>Department of Aging – Administrative Costs</u></p> <p>The federal government provides Title XIX federal financial participation to the California Department of Aging (<b>CDA</b>) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services and the Multipurpose Senior Services Program.</p> <p><b><u>The Department also provides enhanced federal funding to CDA for administrative costs related to services provided to eligibles utilizing Aging and Disability Resource Centers (ADRC).</u></b></p>
H 8	(PC-122)	X	X	<p><u>PACE: Program of All-Inclusive Care for the Elderly</u></p> <p>The Department contracts with PACE organizations in various counties for risk-based capitated care of the frail elderly. PACE programs provide all Medi-Cal state plan services (including long-term services and supports) as well as any other services determined necessary by the PACE interdisciplinary team. PACE programs enroll Medi-Cal and Medi-Cal/Medicare (dual eligible) beneficiaries who are determined by the Department to meet the skilled nursing or intermediate care facility level of care.</p> <p>PACE rates are based upon historical Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits (UPL). <del>The Department has proposed Trailer Bill Language</del> <b><u>is working with PACE organizations and proposing changes to current law</u></b> to transition from a UPL-based methodology to an actuarially sound experienced based methodology <b><u>in alignment with the Department’s goal for standardization of managed care rate methodologies.</u></b> PACE rates are set on a calendar year basis, to coincide with the time period of the contracts. <b><u>The anticipated effective date of the new rate methodology will be in FY 2015-16.</u></b></p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
H 9	(PC-126) X (PC-141)	X	X	<p><u>Senior Care Action Network</u></p> <p>The Senior Care Action Network (SCAN) is a Medicare Advantage Special Needs Plan located in Long Beach and coordinates and provides services in designated areas of Los Angeles, San Bernardino, and Riverside counties. The Department received approval from CMS to prepare a comprehensive risk managed care contract authorized under 1915a to fund State Plan Only Medi-Cal services to its members. SCAN provides medical, social, and case management services to Medicare beneficiaries ages 65 and over in Medi-Cal's aged, disabled, and long term care aid group categories (dual eligibles). All necessary medical services are provided by SCAN. Enrollees who are certifiable for skilled nursing facility (SNF) or intermediate care facility (ICF) levels of care are eligible for additional HCBS. SCAN <del>holds</del> <b><u>had</u></b> a five-year contract with the Department <b><u>that ended on December 31, 2012, but was extended for two additional years through December 31, 2014.</u></b> The term of the current SCAN contract is January 1, 2008 through December 31, 2012. The Department does not plan to renew the SCAN contract. A one-year extension for January 1, 2013 through December 31, 2013 has been executed to facilitate transition of the SCAN Medi-Cal population to existing Medi-Cal programs. <b><u>The extension of the contract facilitates the transition of the SCAN Medi-Cal population into existing Medi-Cal programs, including the Cal MediConnect health plan.</u></b></p> <p>Rates are determined by federal law on an actuarially sound basis. In addition, California state law requires that rates be no more than the rates determined on a FFS equivalent basis. Beginning January 1, 2009, SCAN's rates are re-determined on a calendar year basis to coincide with the time period covered by its contract. <del>To determine 2009 rates for dually eligible enrollees, SCAN provided the Department with a bid based upon its costs for Medi-Cal services rendered to this population. To determine 2009 rates for nursing home eligible participants, the Department used cost data for MSSP as a point of comparison and made adjustments to SCAN's bid. Rates through 2013 are developed based on the plans' actual experience.</del> <b><u>To determine 2014 rates, SCAN will submit a bid based upon costs for Medi-Cal services rendered to its respective population, with the Department using Medi-Cal costs of equivalent populations as comparison points to make adjustments to the bid.</u></b> AB</p>

**HOME & COMMUNITY BASED SERVICES:  
OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

				1422 (Chapter 175, Statutes of 2009) imposed an additional tax (Gross Premium tax) on the total operation revenue of Medi-Cal Managed Care plans. Beginning January 1, 2010, the Gross Premium tax revenue was incorporated into the SCAN rates retroactive to January 1, 2009.
H 10	(OA-49) (PC-44)	X	X	<p><u>Pediatric Palliative Care Waiver</u></p> <p>AB 1745 (Chapter 330, Statutes of 2006) required the Department to submit an application to CMS for a federal waiver for a Pediatric Palliative Care Pilot Project and mandates the Department to evaluate the pilot project. An independent evaluation of the waiver is also required to meet federal assurances.</p> <p>Effective July 2013, the participating agencies will receive reimbursement for administrative costs.</p>
H 11	(PC-45)	X	X	<p><u>SF Community-Living Support Benefit Waiver</u></p> <p>The San Francisco (SF) Community- Living Support Benefit Waiver implements AB 2968 (Chapter 830, Statutes of 2006), which requires the Department to develop and implement a community-living support benefit for Medi-Cal beneficiaries 21 years of age and older, residing in the City and County of SF who would otherwise be residing in nursing facilities or be rendered homeless. The Department worked with the SF Department of Public Health to develop this program as a 1915(c) HCBS waiver.</p> <p>Eligible participants will have full-scope Medi-Cal or share-of-cost Medi-Cal for services to be rendered in Residential Care Facilities for the Elderly (RCFEs), Adult Residential Facilities, or in independent residency units made available by the Direct Access to Housing (DAH) program.</p> <p>The City and County of San Francisco will pay for the non-federal share of the waiver costs through the utilization of CPEs to obtain federal funding for this project. On May 22, 2012, CMS approved the waiver with an effective date of July 1, 2012 through June 30, 2017.</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 12	(PC-35)	X	X	<p><u>Additional HCBS for Regional Center Clients</u></p> <p>The Department submitted a 1915(i) Home and Community-Based Services (HCBS) state plan amendment (SPA) to CMS in December 2009. The SPA requests inclusion of certain services provided by the State's Regional Center (RC) network of non-profit providers to persons with developmental disabilities. RC clients 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. <del>Approval of the SPA is expected in FY 2012-13, with a retroactive date of October 1, 2009.</del> <b><u>The SPA was approved April 25, 2013, retroactive to October 1, 2009.</u></b> ABX3 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. An additional SPA proposes to restore reimbursement for the eliminated services effective October 1, 2010. This will enable persons with developmental disabilities access to HCBS State Plan benefits, other community services, activities, and resources.</p> <p>A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011. Per CMS guidance, this SPA will be modified to add infant development services as an EPSDT benefit.</p> <p>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.</p>
H 13	(OA-44)	X	X	<p><u>CCT Enrollment – Expanded Outreach Administrative Costs</u></p> <p>Pursuant to the Patient Protection and Affordable Care Act, the Department applied for and was awarded grant funding to cover administrative costs needed to increase California Community Transitions (CCT) participation. The grant requires the Department to foster collaborations between the existing Aging and Disability Resource Connection (ADRC) programs and CCT lead organizations to increase CCT enrollment. The costs incurred for these activities are 100% federally funded.</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 14	(PC-46)	X	X	<p><u>Quality of Life (QoL) Surveys for Community Care Transitions (CCT) Participants</u></p> <p>As a condition of the Money Follows the Person Rebalancing Demonstration Grant (MFP), CMS requires the Department to conduct QoL surveys with CCT/MFP transitioned Medi-Cal beneficiaries within specified timeframes and follow a specific <b>survey</b> methodology. CCT/MFP has participation agreements with lead organizations, which are Medi-Cal home and community-based services providers, to conduct these QoL surveys 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. The costs of conducting the surveys are 100% federally funded.</p>
H 15	<del>(PC-32)</del> <del>(PC-FI)</del> (OA-20)	X	X	<p><u>ADHC Transition</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program in FY 2011-12. <del>As a result of</del> <b><u>Resulting from</u></b> the settlement of the lawsuit <i>Darling et al. v. Douglas et al.</i> which challenged the elimination of ADHC services, the ADHC benefit was extended until March 31, 2012. Effective April 1, 2012, an optional Medi-Cal benefit called Community-Based Adult Services (CBAS) was made available under the 1115 BTR Waiver, to eligible individuals as a Medi-Cal Fee-For-Service (FFS) benefit.</p> <p><del>On July 1, 2012, CBAS transitioned into five County Organized Health Systems (COHS) managed care health plans. On October 1, 2012, CBAS transitioned into Two-Plan managed care and Geographic Managed Care plans, as well as one remaining COHS plan. The costs were built into the capitation rate. <b><u>As of October 1, 2012, CBAS was transitioned into all managed care health plans.</u></b></del></p> <p>For those CBAS eligible beneficiaries residing in geographic areas where managed care is not available, Medi-Cal FFS provides CBAS benefits. CBAS eligible beneficiaries in managed care counties who do not qualify for managed care enrollment or have an approved medical exemption are eligible to receive:</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- CBAS if a CBAS Center is available in their geographic area, or
- Unbundled CBAS if CBAS Centers became unavailable in their geographic areas.

Beneficiaries determined not eligible for CBAS, who received ADHC services between July 1, 2011 and February 29, 2012 are eligible for Enhanced Case Management (ECM) through Medi-Cal FFS or a Medi-Cal Managed Care Health Plan, as a result of the settlement agreement.

The Department has developed and mailed beneficiary notices informing beneficiaries of their eligibility for CBAS services, how to receive CBAS services, and for beneficiaries that are not eligible for CBAS, how to receive other services such as ECM.

~~There will be associated~~ **Associated** transition costs to **have been incurred by** the State due to Fair Hearing outcomes and penalties, ~~special mailings/letters, updates to informing material packets, and provider directories.~~

H 16 (PC-201) X

### IHSS Reduction in Service Hours

AB 1612 (Chapter 725, Statutes of 2010), enacted a 3.6% reduction of IHSS service hours. Recipients may determine which of their services will be impacted by the reduction. CDSS implemented this reduction on February 1, 2011. This reduction ~~will sunset~~ **expired** June 30, 2013

In March 2013, a settlement was reached in the *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger* lawsuits. The settlement provides that commencing July 1, 2013, the IHSS program will continue the 3.6% reduction of service hours with an additional 4.4% reduction, for a total of 8%. **The reduction decreases to 7% in FY 2014-15 and may be offset if a provider assessment is developed.**

**BREAST AND CERVICAL CANCER TREATMENT: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

**BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
BC 1 (PC-3)	X	X

Breast and Cervical Cancer Treatment Program

The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income at or below 200% of FPL. Enhanced Title XIX funding is claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope, no cost Medi-Cal benefits for the duration of treatment for women under age 65 who are citizens or immigrants with satisfactory immigration status and who have no other health coverage. The BCCTP also includes a state-funded program that provides cancer and cancer-related treatment services only to persons not eligible for Medi-Cal. The state-funded program is 100% GF, but may receive Safety Net Care Pool funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver. Coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Women with inadequate health coverage, women over the age of 65, undocumented women of any age, and males are eligible for the state funded program. Undocumented women under age 65 are also eligible for federally funded emergency services and pregnancy-related and state-only long-term care services for the duration of their cancer treatment.

Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers, which in California are Every Woman Counts and Family PACT Program providers, using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. The Department's Eligibility Specialists (ES) review the Internet-based application forms and determine regular BCCTP eligibility under the state and federal components. The ES may need to request additional information from the applicant to determine appropriate eligibility under the BCCTP.

With additional staffing, the Department began processing annual redeterminations. Redeterminations are done for beneficiaries in the BCCTP federally-funded aid codes, as well as for those in the BCCTP State-funded aid codes who receive federally-funded emergency coverage. Those persons determined no longer BCCTP program eligible are referred to the counties to determine if they are eligible for any other Medi-Cal program. For those

**BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

determined by the counties not to be eligible for any other Medi-Cal program, a determination will be made if they are eligible for the State-funded BCCTP. Current managed care rates fully incorporate BCCTP costs.

BC 2 (PC-3)    X    X

Breast and Cervical Cancer Treatment Program – Premium Payment

Effective January 1, 2002, under the state funded portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and/or cervical cancer who have other health insurance but are underinsured. Eligibility is limited to 18 months for breast cancer and 24 months for cervical cancer. The criteria for participation in the state funded premium payment program include the following:

- Family income at or below 200% of FPL as determined by the enrolling provider,
- California resident,
- Other health coverage with premiums, deductibles and copayments exceeding \$750 in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination,
- Diagnosis of breast and/or cervical cancer and in need of treatment,
- Not eligible for full-scope, no cost Medi-Cal.

BC 3 (OA-12)    X    X

BCCTP Postage and Printing

Postage and printing costs related to the eligibility determination process for the Breast and Cervical Cancer Treatment Program are budgeted in local assistance, including postage-paid return envelopes for counties to mail copies of DRA/citizenship documentations received from BCCTP beneficiaries. Costs for the state funded component of the program are 100% General Fund, and are included in the Postage and Printing policy change. Mailings include annual redetermination packets to beneficiaries in the federal BCCTP program, retroactive Medi-Cal applications, letters to all applicants to request additional information, notices of approval or denial of eligibility, and referral packets to the counties for redetermination under other Medi-Cal programs as required under SB 87 when a federal BCCTP beneficiary is determined ineligible for full-scope Medi-Cal under BCCTP.

**PHARMACY: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

PH 0.1(PC-211)      X      MCO Supplemental Drug Rebate

The Department has proposed legislation to negotiate state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels for drugs provided through Medicaid MCOs. 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.

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 1 (PC-54)	X	X	<p><u>Non FFP Drugs</u></p> <p>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 CMS. The Department has established claiming procedures to ensure that FFP is claimed correctly. Effective March 2007, an automated quarterly report identifies the costs of drugs for which there is no FFP. This report is used to reduce the FFP. <del>In October 2010, an analysis of the non-FFP drug reports determined that these reports were not accurately capturing non-FFP drug claims. The reports were revised and then re-run for the period FY 2004-05 through FY 2009-10. As a result, a larger number of claims were identified as being ineligible for FFP. The Department will reimburse CMS for the identified non-FFP drug costs, retroactive to FY 2004-05.</del></p>
PH 2 (PC-57)	X	X	<p><u>Family PACT Drug Rebates</u></p> <p>The Department collects rebates for family planning drugs covered through the Family PACT program.</p>
PH 3 (PC-60)	X	X	<p><u>State Supplemental Drug Rebates</u></p> <p>The Department negotiates state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels. As with the federal drug rebates, the Department estimates the state supplemental rebate amounts by using actual fee-for-service trend data for drug expenditures and applying a historical percentage of actual amounts collected to the trend projection.</p>
PH 4 (PC-61)	X	X	<p><u>Federal Drug Rebate Program</u></p> <p>Federal law requires drug manufacturers to provide rebates to the federal government and the states as a condition of FFP in the states' coverage of manufacturers' drug products. The manufacturers have 38 days to make payment after being billed. The ACA increases the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increases the multi-source drug rebate from 11% of AMP to 13%. CMS is claiming 100% of the 8% single source and 2% multi-source differential in the rebate increases. This will result in a cost to the Medi-Cal program because California currently collects rebates at the higher</p>

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.
PH 5 (PC-56)	X	X	<p><u>Medical Supply Rebates</u></p> <p>The Department negotiates maximum acquisition cost (MAC) and rebates with manufacturers for diabetic test strips and lancets to provide savings to the Department. Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are sent quarterly to manufacturers.</p> <p>The product reimbursement rates for diabetic test strips and lancets are based on the contracted MAC.</p> <p>On January 1, 2013, newly negotiated three-year contract terms went into effect and reduced the Department's net cost per claim.</p>
PH 6 (PC-59)	X	X	<p><u>Aged and Disputed Drug Rebates</u></p> <p>The Department collects drug rebates as required by federal and state laws. The Department has completed its work on the oldest aged rebate disputes (1991-96) and <del>is awaiting final agreements from a few pharmaceutical companies, which account for the majority of the amount in dispute, before closing out the time period. The Department has begun work</del> <b>is working</b> on disputes for the 1997-2002 time period. <b><u>for more recent periods.</u></b></p> <p>Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and to receive rebate payments.</p>
PH 7 (OA-51)	X	X	<p><u>Epocrates</u></p> <p>The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) in the Epocrates system. Epocrates RX™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country. Epocrates provides the Department with an opportunity to reach a large network of health professionals via a point-of-care clinical reference for physicians and other health professionals. Epocrates' formulary is free to health professional users.</p>

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
PH 8 (PC-55)	X	X	<p><u>BCCTP Drug Rebates</u></p> <p>Enhanced Title XIX Medicaid funds (65% FFP/35% GF) 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. Beginning January 2010, the Department is collecting drug rebates for the federal BCCTP program. Manufacturers were invoiced retroactively to January 1, 2002. By agreement with CMS, rebates for beneficiary drug claims for the federal portion of the BCCTP program (emergency and prenatal services) for those without satisfactory citizenship or immigration status will not be invoiced.</p>
PH 9 (PC-NA)	X	X	<p><u>Physician-Administered Drug Reimbursement</u></p> <p>This assumption has been moved to “Fully Incorporated Into Base Data/Ongoing” section.</p>
PH 10(OA-60)		X	<p><u>Rate Studies for MAIC and AAC Vendor</u></p> <p>Welfare and Institutions Code, Section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies’ acquisition costs and to update the MAICs at least every three months. AB 102 (Chapter 29, Statutes of 2011) authorized the Department to develop a new reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price (AWP). In order to obtain the information from providers necessary to establish the MAICs and AACs, the Department <del>will</del> <b>must</b> hire a contractor <del>in FY 2012-13 to survey drug price information from the Medi-Cal pharmacy providers and update AACs and MAICs on an ongoing basis.</del> Currently, the Department is subject to a court injunction which precluded implementation of the MAIC methodology, as amended by ABX4 5 (Chapter 5, Statutes of 2009). However, MAICs based on the new reimbursement benchmark, AACs, are not subject to that injunction.</p> <p><b><u>The procurement is anticipated to occur in FY 2014-15 following the settlement of litigation and approval of the State Plan Amendment.</u></b></p>

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 11 (PC-NA)	X	X	<u>Sunset of Specialty Drug Contracts</u>
			This assumption has been moved to “Fully Incorporated Into Base Data/Ongoing” section.
<b><u>PH 12 (PC-53)</u></b>	<b>X</b>	<b>X</b>	<b><u>Restoration of Enteral Nutrition Benefit</u></b>
			<b><u>The Omnibus Health Trailer Bill, AB 82 (Chapter 23, Statutes of 2013), added Section 14132.86 to the Welfare and Institutions Code and removes the tube feeding restriction to enteral nutrition products benefit coverage for adult beneficiaries, and broadens the covered benefit subject to a Medi-Cal list and utilization controls.</u></b>

**DRUG MEDI-CAL: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
D 0.1 (OA-58)		X	<p><u>Drug Medi-Cal County Administration</u></p> <p>Effective July 1, 2014, counties may claim reimbursement for administrative costs related to Drug Medi-Cal (DMC) services through a new quarterly invoicing process. As a result of this change, the Department reimbursement rate-setting methodologies will exclude county administrative expenses to reimburse counties for the federal share of the county-certified direct service costs.</p>
D 0.2 (OA-80)	X	X	<p><u>Third Party Validation of Certified Providers</u></p> <p>The Department will procure a vendor, from the California Multiple Award Schedule, to conduct a third party validation of all Drug Medi-Cal program service providers, pre and post certification.</p> <p>The third party validation will enhance anti-fraud activities that will enable the Department to assess program providers, provider risk, demographic coverage, and generate alerts of changes in status by matching providers through various sources of information. Matching sources will include but are not limited to: (a) Federal Exclusion Records; (b) State Exclusion Records; (c) Federal Death Records; (d) State Licensure Sanctions; and (e) National Provider Identification (NPI) Deactivations.</p>
D 0.3 (PC-203)	X	X	<p><u>Provider Fraud Impact to DMC Program</u></p> <p>Fraudulent Medi-Cal billing practices have been determined to have primarily occurred in the DMC Outpatient Drug Free Treatment Services program. The Department has taken significant steps to address fraud in the Drug Medi-Cal program.</p> <p>A statewide enforcement sweep was launched in July. As of August, 30, 2013, the Department has issued temporary suspensions for 139 out of the 1,063 certified DMC providers and lodged 51 Credible Allegations of Fraud with the California Department of Justice for potential prosecution.</p>

## DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
D 1	(PC-63)	X	X	<p><u>Perinatal Residential Treatment Services</u></p> <p>The <del>Perinatal</del> Residential Treatment Services program provides rehabilitation services to <del>pregnant and postpartum women</del> <b>beneficiaries</b> with substance use disorder diagnoses in a non-institutional, non-medical, residential setting. Each beneficiary resides on the premises and receives support in her effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems. The cost of room and board is not reimbursed under the Medi-Cal program.</p> <p><del>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program</del> <b><u>Beginning January 1, 2014, as a result of California's adoption of the ACA, the previous limitation on this service to only pregnant and postpartum beneficiaries will be removed and all Medi-Cal beneficiaries who meet the service criteria may receive the service.</u></b></p>
D 2	(PC-65)	X	X	<p><u>Day Care Rehabilitative Intensive Outpatient Services</u></p> <p><del>Day Care Rehabilitative</del> <b><u>Intensive Outpatient</u></b> services provide outpatient counseling and rehabilitation services at least three hours per day, three days per week to persons with substance use disorder diagnoses.</p> <ul style="list-style-type: none"> <li><del>• who are pregnant or in the postpartum period,</del></li> <li><del>• and/or to EPSDT eligible beneficiaries.</del></li> </ul> <p><del>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</del> <b><u>Beginning January 1, 2014, as a result of California's adoption of the ACA, the previous limitation to only pregnant, postpartum or EPSDT eligible beneficiaries will be removed and all Medi-Cal beneficiaries who meet the service criteria may receive the service.</u></b></p>
D 3	(PC-64)	X	X	<p><u>Outpatient Drug Free Treatment Services</u></p> <p>The Outpatient Drug Free (ODF) Treatment program is designed to stabilize and rehabilitate persons with substance use disorder diagnoses in an outpatient setting when prescribed by a physician</p>

## DRUG MEDI-CAL: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

as medically necessary. Each ODF participant receives at least two group, face-to-face, counseling sessions per month. Face-to-face individual counseling is limited to intake, crisis intervention, collateral services, and treatment and discharge planning.

~~Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program .~~

D 4 (PC-62) X X

### Narcotic Treatment Program

The Narcotic Treatment Program provides outpatient methadone or levorphanol (LAAM), which is not currently manufactured, **maintenance** services directed at stabilization and rehabilitation of persons with opioid dependency and diagnoses of substance use disorder diagnoses.

The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions. ~~The Narcotic Treatment Program does not include detoxification.~~

~~Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.~~

D 5 (PC-NA)

### Naltrexone Treatment Services

This assumption has been moved to the "Info Only" section.

D 6 (PC-67) X X

### Drug Medi-Cal Program Cost Settlement

The Drug Medi-Cal program reimburses counties and contracted providers for the alcohol and drug treatment services that they provide to Drug Medi-Cal beneficiaries. The Drug Medi-Cal program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the rate cap. At the end of each fiscal year, non-Narcotic Treatment Program (non-NTP) providers must submit actual cost information. The Drug Medi-Cal program completes an interim settlement after receipt and review of the provider's cost report and approved units of service. Within three years of the interim settlement, the program must conduct an audit to complete a final settlement. If the program does not complete

**DRUG MEDI-CAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

the audit within three years, the interim settlement becomes the final settlement.

Reimbursement for non-Narcotic Treatment Program (NTP) providers is limited to the lowest of the following costs:

- Provider’s usual and customary charges to the general public for the same or similar services,
- Provider’s allowable costs, or
- Drug Medi-Cal statewide maximum allowance for each non-NTP service modality.

Reimbursement to NTP providers is limited to the lowest of the following costs:

- Provider’s usual and customary charges to the general public for the same or similar services,
- Drug Medi-Cal uniform statewide ~~daily~~ reimbursement rate for the service.

D 7    (PC-68)    X        X

Annual Rate Adjustment

The Department annually adjusts the Drug Medi-Cal rates. For non-NTP services and NTP counseling services. The Department annually sets rates based on the lower of either the cost report data or the Fiscal Year 2009-10 rates adjusted by cumulative growth of the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies as reported by the Department of Finance. For the NTP dosing service, the Department annually sets rates based on the lower of either updated component cost data or the Fiscal Year 2009-10 rates adjusted by the cumulative growth in the Implicit Price Deflator. The annual rate adjustment is effective July 1st of each year.

**Effective July 1, 2014, Drug Medi-Cal reimbursement rate setting methodologies will exclude county administrative expenses. The Department will reimburse counties quarterly for Drug Medi-Cal county administration expenses.**

## MENTAL HEALTH: NEW ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

## MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MH 1(PC-69) (PC-70)	X	X	<p><u>Specialty Mental Health Services</u></p> <p>The Medi-Cal Specialty Mental Health Services waiver program provides inpatient, targeted case management, and rehabilitative mental health services to adults and children <del>and youth under 21 who are</del> enrolled in the Medi-Cal program and meet the medical necessity criteria.</p> <p>Adult: The mental health plan authorizes the delivery of specialty mental health services in accordance with state regulations and contract requirements for <del>service authorization</del> <b>services</b> provided to adults.</p> <p>Children: The mental health plan authorizes the delivery of specialty mental health services in accordance with state regulations and contract requirements for <del>service authorization</del> <b>services</b> provided to children, which includes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specialty mental health services. EPSDT specialty mental health services include all services that are required to correct or improve medical health condition diagnosed by a doctor or mental health care provider as long as the service is covered under the federal Medicaid program.</p> <p>The Department contracts with a mental health <del>plan in each county</del> <b>plans</b>, to provide or arrange and pay for the provision of specialty mental health services to all individuals, <del>in that county, who are</del> enrolled in the Medi-Cal program and <del>and</del> <b>that</b> meet the medical necessity criteria for <del>the</del> specialty mental health services.</p> <p><del>Effective July 1, 2012, the Department of Mental Health (DMH) program staff and associated funding was shifted to the Department.</del></p>
MH 2 (PC-75)	X	X	<p><u>Healthy Families Program SED</u></p> <p>The Healthy Families Program (HFP) provides low cost insurance for eligible children under the age of 19 whose families:</p> <ul style="list-style-type: none"> <li>• Do not have health insurance,</li> <li>• Do not qualify for zero share of cost Medi-Cal, and</li> <li>• Income is at or below 250 percent of the federal poverty level.</li> </ul>

**MENTAL HEALTH: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Mental health services for the HFP subscribers who are Seriously Emotionally Disturbed (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 mental health department assumes responsibility for the treatment of the HFP enrollee’s SED condition, it claims for the services. County mental health departments receive 65% federal reimbursement for services provided to HFP subscribers and pay for the 35% match with realignment dollars or other local funds.

~~Effective July 1, 2012, the DMH functions related to the HFP SED Benefit and associated funding was shifted to the Department.~~

~~No sooner than **Beginning** January 1, 2013, the HFP will cease **ceased** to enroll new subscribers and **the current** HFP subscribers will transition **were phased** into **the** Medi-Cal **program** through a phase-in methodology.~~

MH 3 (PC-80) X X  
 (PC-82)

IMD Ancillary Services

Effective July 1, 1999, the cost of ancillary services for Medi-Cal beneficiaries who are ages 22 through 64 residing in Institutions for Mental Diseases (IMDs), was entirely state-funded. In 2008, the entire cost became a county responsibility.

MH 4 (PC-79) X X

Siskiyou County Mental Health Plan Overpayment

The Department has identified overpayments to Siskiyou County Mental Health Plan (MHP) due to inappropriate Medi-Cal billing practices. The Department must return the overpaid FFP reimbursements to the CMS. Siskiyou County and the State are ~~currently negotiating~~ **negotiated** a plan for the county to reimburse the State for the repayment.

## MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
MH 5 (PC-83) (OA-5)	X	X	<p><u>Interim and Final Cost Settlements—Specialty Mental Health Services</u></p> <p>Within two years following the end of a fiscal year, the Department <del>must reconcile interim settlements</del> <b><u>reconciles interim payments</u></b> to MHPs for children, adults, and healthy families <b><u>and adults</u></b> specialty mental health services to county <b><u>via interim</u></b> cost report <b><u>settlements.</u></b> <del>and process</del> <b><u>The Department processes</u></b> correcting payments or recoupments <b><u>depending on each</u></b> <b><u>county’s interim cost report settlement amount.</u></b> <b><u>Subsequent to the interim settlement, the Department conducts a final cost settlement audit resulting in a final audit payment or recoupment.</u></b></p>
MH 6 (PC-81)	X	X	<p><u>Chart Review</u></p> <p>The Department conducts on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries. <b><u>When documentation of a specialty mental health service does not meet medical necessity or other criteria, the FFP portion of the paid claim is recouped.</u></b></p>
MH 7 (PC-NA)	X		<p><u>Specialty Mental Health Lawsuits</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
MH 8 (PC-78)	X	X	<p><u>Solano County SMHS Realignment Carve-Out</u></p> <p>Prior to FY 2012-13, the Medi-Cal managed care program “carved in” specialty mental health services for Solano County.</p> <p>Under the 2011 Realignment, Solano County decided to exercise their right to assume responsibility for providing or arranging for the specialty mental health services from the Medi-Cal Managed Care Plan, effective July 1, 2012.</p> <p>The Medi-Cal Managed Care contract was reduced for the mental health services component and the local realignment funding to Solano County was increased by the same amount.</p>

## MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MH 9 (PC-77)	X	X	<p><u>Over One-Year Claims</u></p> <p>County MHPs 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.</p>
MH 10 (OA-3)	X	X	<p><u>County Specialty Mental Health Administration</u></p> <p>Counties may obtain federal reimbursement for certain costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.</p>
MH 11 (OA-14)	X	X	<p><u>County Utilization Review and Quality Assurance</u></p> <p>County Utilization Review (UR) and Quality Assurance (QA) activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 50% or 75% depending on the claim.</p>
MH 12 (OA-55) (PC-74)	X	X	<p><u>Katie A. v. Diana Bontá – Special Master</u></p> <p>On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in <i>Katie A. v. Diana Bontá</i>, requiring the provision of 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. On October 13, 2011, the parties began a new series of Special Master meetings to develop a plan for, and begin, settlement implementation. The Special Master is being funded by the Department and CDSS. On December 13, 2012, the court approved the implementation plan drafted by the parties.</p>

## MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

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) and Intensive Home-Based Services (IHBS) and were effective beginning January 1, 2013. Also as a result of the lawsuit, a new service called Therapeutic Foster Care (TFC) will be implemented beginning January 1, 2014 or after CMS approval of the TFC service type.**

MH 13 (OA-25)    X    X

### PASRR

Federal regulations mandate that the Department have an independent contractor complete all Level II Preadmission Screening and Resident Review (PASRR) Evaluations. QTC Medical Group, Inc. completes Level II evaluations for the federally mandated PASRR program. QTC provides licensed clinical evaluators to conduct a face-to-face mental status examination and psychosocial assessment for individuals identified with mental illness upon admission to a nursing facility. QTC enters Level II findings into the PASRR database.

The current contract ends in June 2014. The FY 2012-13 budget is **was** included in support, but beginning with FY 2013-14 it **will** be **is** part of the local assistance estimate.

In addition, the Department is requesting funding for a PASRR information technology (IT) project to design, test, and implement a web based automated system to bring the preadmission Level I Screening, Level II evaluation, and Level II determination processes into compliance with federally mandated regulations. The IT project will replace an inefficient mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The Department will save money by not contracting with a consultant to support the current mainframe and by hosting the new application in-house. The project will be funded 75% FFP and 25% SGF.

MH 14(PC-72)    X    X

### Elimination of State Maximum Rates

Assembly Bill 1297 (Chapter 651, Statutes of 2011) eliminated the state maximum rates paid for Medi-Cal specialty mental health

## MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

services. 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 likely be equal to the aggregate of the lower of allowable cost or customary charge for all specialty mental health services provided by the mental health plan and its network of providers.

**MH 15(PC-76)**    **X**    **X**

### **Investment in Mental Health Wellness**

**SB 82 (Chapter 34, Statutes of 2013) created the Investment in Mental Health Wellness Act of 2013. SB 82 adds 25 mobile crisis support teams and 2,000 crisis stabilization and crisis residential treatment beds over the next two years to expand community-based resources and capacity. The Act also adds 600 triage personnel over the next two years to assist individuals with gaining access to medical, specialty mental health care, alcohol and other drug treatment, social, educational, and other services.**

**MH 16(PC-18)**    **X**    **X**

### **Parole Mental Health and Medi-Cal Expansion**

**SB 82 (Chapter 34, Statutes of 2013), establishes the Investment in Mental Health Wellness Act of 2013. Through the Act, the Legislature increased federal funding to the Department to provide services for mentally ill inmates released after January 1, 2014. The State expands eligibility to additional parolees under the ACA.**

**MH 17(PC-71)**    **X**    **X**

### **Specialty Mental Health Services Supplemental Reimbursement**

ABX4 5 (Chapter 5, Statutes of 2009) creates a provision to allow an eligible public agency receiving reimbursement for specialty mental health services provided to Medi-Cal beneficiaries to also receive supplemental Medi-Cal reimbursement up to 100% of actual allowable costs.

The supplemental payment amount, 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. The non-federal share of costs used to draw down FFP for the supplemental payments will be expended from the public agency and will not involve General Fund dollars.

## MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

The Department submitted a SPA to CMS to obtain approval for the new supplemental payment program. The Department is providing additional information to CMS. Upon approval, supplemental payments will be authorized retroactive to January 2009, with payments expected to be made beginning FY 2013-14.

The Supplemental Payment Program will be included in the Specialty Mental Health Services (SMHS) Waiver.

## 1115 WAIVER-MH/UCD & BTR

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and a new demonstration was approved by CMS.

The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) was approved effective November 1, 2010, for five years. This Demonstration extends and modifies the previous MH/UCD. Many of the features of the previous Demonstration have been continued with modifications as noted in the individual assumptions. There is no new funding for the South LA Preservation Fund and the Distressed Hospital Fund. Other significant changes in the new Demonstration are:

- Expansion of the state-only programs that may be federalized up to a maximum of \$400 million in each year of the waiver;
- Creation of a Delivery System Reform Incentive Pool (DSRIP) fund to support public hospital efforts in enhancing quality of care and health of patients;
- Expansion of the current Health Care Coverage Initiative (HCCI) by creating a separate Medicaid Coverage Expansion (MCE) program using new funding for those eligibles who have family income at or below 133% of the Federal Poverty Level.

**1115 WAIVER – MH/UCD & BTR: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

## 1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 1	(PC-88) (PC-104)	X	X	<u>MH/UCD &amp; BTR—Safety Net Care Pool</u>

Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions (STCs) of the MH/UCD, a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503.

The federal funds that the Department claims from the SNCP are based on the following Certified Public Expenditures (CPEs):

- The CPEs of the Designated Public Hospitals (DPHs); and
- The CPEs of the following four state-only programs:
  - Medically Indigent Adult Long-Term Care Program;
  - Breast and Cervical Cancer Treatment Program;
  - Genetically Handicapped Person's Program; and
  - California Children's Services Program.

Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

The reconciliation process for each Demonstration Year (DY) may result in an overpayment or underpayment to a DPH, which 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 SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The new BTR effective November 1, 2010, makes several changes to the SNCP funding. SNCP payments to DPHs are for uncompensated care provided to individuals with no source of third party coverage for the services they received. AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

the BTR to determine (1) the federal disproportionate share hospital allotment for DPHs (2) SNCP Uncompensated Care payments, (3) DSRIP payment to DPHs. SNCP funding for the DSRIP, Designated State Health Programs (DSHP), the Low Income Health Program–Medicaid Coverage Expansion (LIHP-MCE) and the Low Income Health Program-Health Care Coverage Initiative (LIHP-HCCI) are included in separate assumptions.

W 2 (PC-85) X X

**MH/UCD & BTR—DSH Payments**

Effective for dates of services on or after July 1, 2005, based on SPA 05-022, approved in May 2006, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by Disproportionate Share Hospitals (DSH). Non-emergency services for unqualified aliens are eligible for DSH program funding.

DPHs claim reimbursement from the DSH allotment for up to 100% of their uncompensated care costs based on CPEs. These CPEs constitute the non-federal share of payments. Under this new methodology, each DPH certifies its Medi-Cal Managed Care and psychiatric inpatient and outpatient shortfall and its uninsured costs to the Department. The Department submits claims for federal reimbursement based on the DPHs' CPEs. The federal reimbursement that is claimed based on the CPEs is drawn from the Federal Trust Fund and passes through the Demonstration DSH Fund, Item 4260-601-7502.

DPHs also may claim up to 175 percent of uncompensated care costs. (Two University of California hospitals are not eligible for 175% reimbursement.) Intergovernmental transfers (IGTs) from the government entity with which the DPH is affiliated constitute the non-federal share of these payments. These IGTs are deposited into the MIPA Fund, Item 4260-606-0834 and are used to claim federal reimbursement. The federal reimbursement that is claimed based on the IGTs is drawn from the Federal Trust Fund.

Non-Designated Public Hospitals (NDPHs) will claim reimbursement from the DSH allotment for up to 100% of their uncompensated Medi-Cal and uninsured costs using GF as the non-federal share of payments. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Based on SPA 05-022, private hospitals on the final DSH list receive a total funds payment of \$160.00 in annual DSH payments. The total payment of \$160.00 is comprised of 50% FFP payments from the federal DSH allotment and 50% GF. CMS required that some portion, no matter how small, of the annual DSH allotment go to the private hospitals. They indicated that the amount designated to private hospitals could be as little as \$1.00 per hospital. Since there were approximately 160 private hospitals eligible for DSH payments, it was agreed that \$160.00 would be specified in the SPA. This dollar amount was also agreed to by the DSH Task Force. The requirements of sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code shall be satisfied through the provision of payment adjustments as described in this paragraph.

Each DPH's interim Disproportionate Share Hospital (DSH) payments will be reconciled to its filed Medi-Cal cost report for the fiscal year.

The reconciliation process may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments; and
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DSH payments that the DPHs have received and the DSH payments determined in the reconciliation process.

AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

W 3 (PC-87) X X

MH/UCD & BTR—Private Hospital DSH Replacement

Effective for dates of service on or after July 1, 2005, private hospitals receive DSH replacement payments, the non-federal share of which is funded by the GF. The DSH replacement payments, along with \$160.00 of the DSH payments (see assumption for Hospital Financing DSH Payments), will satisfy the payment obligations with respect to those hospitals under the Federal DSH statute. The federal share of the DSH replacement

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

payments is regular Title XIX funding and is not claimed from the federal DSH allotment.

SB 335 (Chapter 286, Statutes of 2011) reduces Medi-Cal DSH replacement payments to private hospitals by \$75 million GF in FY 2011-12, \$10.5 million GF in FY 2012-13, and \$5.25 million GF in FY 2013-14.

W 4	(PC-89)	X	X	<p><u>MH/UCD &amp; BTR—Private Hospital Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals receive payments from the Private Hospital Supplemental Fund, Item 4260-601-3097. SB 1100 provides a continuous appropriation of \$118.4 million annually from the GF to the Private Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. SB 335 (Chapter 286, Statutes of 2011) reduces this annual appropriation by \$17.5 million in FY 2012-13 and \$8.75 million in FY 2013-14. This funding replaces the aggregate amount the private hospitals received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/Voluntary Governmental Transfers (VGT), Graduate Medical Education Supplemental Payment (Teaching Hospitals), and Small and Rural Hospital Supplemental Payment programs.</p>
W 5	(PC-103)	X	X	<p><u>MH/UCD &amp; BTR—NDPH Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, NDPHs receive payments from the Non-Designated Public Hospital Supplemental Fund, Item 4260-601-3096. SB 1100 provides a continuous appropriation of \$1,900,000 annually from the GF to the Non-Designated Public Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the NDPHs received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/VGT) program.</p>
W 6	(PC-94)	X	X	<p><u>MH/UCD &amp; BTR—DPH Physician and Non-Physician Costs</u></p> <p>Effective for dates of service on or after July 1, 2005 reimbursement based on CPEs will be available to each DPH for the costs incurred for physician and non-physician practitioner professional services rendered to Medi-Cal beneficiaries who are</p>

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

patients of the hospital or its affiliated hospital and non-hospital settings. SPA 05-023 that authorizes federal funding for this reimbursement was approved by CMS in December 2007. CMS approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

W 7	(PC-NA)	X	<u>MH/UCD—Distressed Hospital Fund</u>
			This assumption has been moved to the “Time Limited/No Longer Available” section.
W 8	(PC-105)	X	<u>MH/UCD&amp; BTR—MIA LTC Program– Safety Net Care Pool</u>
			Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded Medically Indigent Adult Long-Term Care program.
W 9	(PC-106)	X	<u>MH/UCD &amp; BTR—BCCTP – Safety Net Care Pool</u>
			Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded portion of the Breast and Cervical Cancer Treatment Program.
W 10	(PC-91)	X	<u>MH/UCD &amp; BTR—CCS AND GHPP – Safety Net Care Pool</u>
			Effective for dates of service on or after September 1, 2005, based on SB 1100, the Department may claim federal reimbursement for the CCS Program and Genetically Handicapped Persons Program (GHPP) from the SNCP established by the MH/UCD and the BTR. 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

## 1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

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.

W 11 (PC-100) X

X

### MH/UCD & BTR—DPH Interim and Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the STCs of the MH/UCD and BTR, each DPH's interim per diem rate is comprised of 100 percent federal funds, based on the reconciliation of each inpatient hospital costs for Medi-Cal beneficiaries to its filed Medi-Cal cost report.

The reconciliation process for each Demonstration Year 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 the share of cost, third liability and Medi-Cal payments.

Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

W 12 (PC-99) X

X

### MH/UCD—Stabilization Funding

Effective for dates of service on or after July 1, 2005 through October 31, 2010, a portion of the total stabilization funding, comprised of FFP and GF, as specified in Section 14166.20 of the W&I code, will be determined as follows:

- Non-Designated public hospitals (NDPHs) will receive total funds payments equal to the difference between the sum of \$0.544 million and 0.64% of the total stabilization funding and the aggregate payment increase in the fiscal year, compared with their aggregate baseline;

## 1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Private hospitals will receive total funds payments equal to the difference between the aggregate payment increase in the fiscal year, compared with their aggregate baseline, and 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 the total stabilization funding with a minimum of \$15.3 million; and
- DPHs will receive GF payments to the extent that the state-funded programs' CPEs are used for FFP from the SNCP and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, private hospitals, and distressed hospitals.

Final reconciliations for the MH/UCD stabilization funding **due to DPHs** will begin in FY ~~2012-13~~ **2013-14**.

W 13 (PC-102) X

### MH/UCD—Health Care Coverage Initiative

An amount of \$180 million in federal funds is available each year in Demonstration Years 3-5 to expand health care coverage to eligible low-income, uninsured persons. SB 1448 (Chapter 76, Statutes of 2006) provided the statutory framework for the Health Care Coverage Initiative (CI) and directed the Department to issue a Request for Applications to enable a county, a city and county, a consortium of more than one county, or a health authority to apply for an allocation of this federal funding. A total of ten programs have been selected to participate in the CI program.

The federal funds available will reimburse the CI counties an amount equal to the applicable FMAP of their CPEs for health care services provided to eligible low-income, uninsured persons. The CI counties will submit their CPEs to the Department for verification and the Department will submit the claim for FFP that will reimburse the CI counties. No GF will be expended for this program.

In FY 2008-09, the Department began reimbursement and interim quarterly payments to the CI counties. The final reconciliation and settlement process may result in payment and recovery in future years.

This initiative ended on October 31, 2010, with the expiration of the MH/UCD. Under the BTR, the CI becomes part of the Low

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			Income Health Program; see the Low Income Health Program assumption.
W 14 (PC-107)	X	X	<p><u>MH/UCD &amp; BTR—DPH Interim Rate</u></p> <p>Effective July 1, 2005, based on SPA 05-021, DPHs no longer received SPCP negotiated per diem rates (50% GF/50% FFP.) DPHs receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal costs trended forward. The interim per diem rates are funded using the hospitals' CPEs to match federal funds. The interim per diem rates consist of 100% federal funds; however, the Medi-Cal inpatient base estimate assumes costs are 50% GF/50% FFP. Therefore, an adjustment is necessary to shift the funding from 50% GF/50% FFP to 100% FFP.</p>
W 15 (PC-97)	X	X	<p><u>MH/UCD &amp; BTR—DPH Interim Rate Growth</u></p> <p>Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on the reported hospitals' Medi-Cal costs trended forward annually. The trend used is to reflect increased costs and is expected to be different from the former CMAC negotiated rate trend for some DPHs. The interim per diem rate consists of 100% FFP.</p>
W 16 (PC-NA)	X		<p><u>MH/UCD—Health Care Coverage Initiative – Administrative Costs</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
W 17 (OA-37)	X	X	<p><u>MMA –DSH Annual Independent Audit</u></p> <p>MMA requires an annual independent certified audit that primarily certifies:</p> <ul style="list-style-type: none"> <li>• That DSH (approximately 150+ hospitals) have reduced their uncompensated care costs by the amount equal to the total amount of claimed expenditures made under section 1923 of the MMA; and</li> <li>• That hospitals' DSH payments do not exceed the costs incurred by the hospitals in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients.</li> </ul>

## 1115 WAIVER – MH/UCD &amp; BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				CMS released the final regulation and criteria for the annual independent certified audit. Each year's annual report is due to CMS by December 31.
W 18	(PC-85) (PC-87)	X		<p><u>MH/UCD &amp; BTR—ARRA – DSH Allotment and DSH Replacement Payments</u></p> <p>California's annual allotment of federal funds for the Disproportionate Share Hospital (DSH) temporarily increased for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the ARRA. The distribution of the DSH allotment is determined by a formula specified in State statute and the State Medi-Cal Plan. When the DSH allotment is increased and more federal funds are available for distribution, the formula results in an increase in General Funds needed as the non-federal share of the DSH payments for NDPHs and DSH replacement payments to private hospitals.</p> <p>The remaining DSH ARRA payments cannot be paid to the hospitals until the entire original DSH allotment is paid out per federal rules, therefore the Department expects to continue to pay DSH ARRA payments in FY <del>2012-13</del> <b>2013-14</b>.</p>
W 19	(PC-NA)	X		<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Available" section.</p>
W 20	(PC-110)	X		<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool</u></p> <p>The MH/UCD made available \$180 million in federal funds via the SNCP annually. This funding was contingent on the Department meeting specific milestones. In Demonstration Years 1 and 2, this funding was unused. The Department will utilize this funding in FY 2009-10, FY 2010-11, and FY 2011-12 to claim federal funds via certified public expenditures. The final reconciliations <del>is expected to begin</del> <b>began</b> in FY 2012-13.</p>
W 21	(PC-86) (PC-92)	X	X	<p><u>BTR—Delivery System Reform Incentive Pool</u></p> <p>The BTR was approved by CMS effective November 1, 2010. Based on the STCs of the demonstration, the SNCP includes a Delivery System Reform Incentive Pool (DSRIP). The DSRIP is</p>

## 1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

established to support California public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Funding is available in five areas:

1. Infrastructure development;
2. Innovation and redesign;
3. Population-focused improvement
4. Urgent improvement in care; and
5. HIV Transition Projects.

AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payment to DPHs.

On June 28, 2012, CMS approved an amendment to the BTR Demonstration that authorizes HIV Transition projects to be included as a category for which additional DSRIP funding is available. DPHs that elect to implement additional DSRIP HIV Transition projects will receive incentive payments under the SNCP upon achievement of project milestones. ~~These projects will be effective from July 1, 2012 through December 31, 2013.~~ **Incentive funding for these projects will be effective from July 1, 2012 through October 31, 2015.**

Intergovernmental transfers (IGTs) ~~will be~~ **are** used as the non-federal share to claim the federal funding **for DSRIP.**

W 22 (PC-84) X  
(PC-90)

### BTR—Low Income Health Program

The BTR was approved by CMS effective November 1, 2010. The BTR modified the HCCI under the MH/UCD to expand health care coverage to low income adults through the Low Income Health Program (LIHP). AB 342 (Chapter 723, Statutes of 2010) and AB 1066 (Chapter 86, Statutes of 2011) authorize the local LIHPs to provide health care services to eligible individuals.

LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). These are county-based elective programs, **which will terminate on December 31, 2013, when these individuals will become eligible for Medi-Cal or the Health Benefits Exchange, as appropriate under the Affordable Care Act.** ~~Under the BTR waiver, the LIHP will expire on December 31, 2013.~~

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The counties use the following methodologies to obtain federal funding:

- CPEs;
- IGTs for capitation rates payments; and
- IGTs for county-owned FQHCs (CMS approved this claiming protocol on February 5, 2013).

If counties that participate in the HCCI under the MH/UCD elect not to participate in the HCCI component of the LIHP, they must continue to provide health care services for existing enrollees and receive federal funding for these services.

- a. MCE will cover individuals who have family incomes at or below 133% FPL. The MCE program is not subject to a federal funding cap.
- b. HCCI will cover individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to a cap of \$180 million for the first three demonstration years and \$90 million for the last year ending December 31, 2013. This cap may vary annually; see the BTR-Health Care Coverage Initiative Rollover Funds assumption.

W 23 (PC-95) X

X

BTR—SNCP Designated State Health Programs

The BTR was approved by CMS effective November 1, 2010. Under the new demonstration, the State may claim up to \$400 million federal funds for certain state-only programs. This claiming has first priority on the SNCP funds.

CPEs from the following programs may be used to draw the federal funds:

- State Only Medical Programs
  - California Children’s 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)

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- Every Woman Counts (EWC)
- Prostate Cancer Treatment Program (PCTP)
- County Medical Services Program (CMSP); effective November 1, 2010 to December 31, 2011.
- Workforce Development Programs
  - Office of Statewide Health Planning and Development (OSHPD)
    - Song-Brown Healthcare Workforce Training Program
    - Steven M. Thompson Physician Corp Loan Repayment Program
    - Mental Health Loan Assumption Program
  - University of California
  - California State University
  - California Community Colleges
- Miscellaneous programs.

\*Separate assumptions address the federal funds for these programs.

W 24 (OA-4)    X    X  
 (PC-FI)

BTR—Low Income Health Program – Administrative Costs

Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the LIHP. These costs will involve both MCE and the HCCI. FFP is available for costs incurred on or after November 1, 2010, through December 31, 2013, that are associated with the start-up, implementation and closeout administration for the LIHP. The federal funding will reimburse the programs an amount equal to 50% of their certified public expenditures for administrative costs.

**Most LIHP individuals will transition into Medi-Cal managed care beginning January 1, 2014. The Department will develop notices informing beneficiaries of the transition process. Beginning November 1, 2013, approximately 600,000 notices are scheduled to be mailed to beneficiaries. Due to the special mailing, there will be associated costs to the State beginning in FY 2013-14.**

W 25 (PC-96)    X

BTR - LIHP - Inpatient Hospital Costs for CDCR Inmates

AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department to claim federal funding for inpatient hospital services for certain State inmates in the California Department of Corrections and Rehabilitation (CDCR) correctional facilities who

## 1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

are enrolled under the LIHP. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those determined eligible by the Department for the LIHP program operated by the counties. The CPEs incurred by the CDCR for inpatient hospital services provided to those inmates eligible for the LIHP will be certified by CDCR. The county LIHP in which the eligible inmate is enrolled will attest to the CDCR CPEs for federal reimbursement. The Department budgets the FFP based on the counties' attestation of the CDCR CPEs.

W 26 (PC-109) X

### Hospital Stabilization

AB 1467 (Chapter 23, Statutes of 2012) provided the authority to redirect private and NDPH stabilization funding that ~~has not yet been paid~~ **was not paid prior to January 1, 2012 to the State General Fund. In FY 2012-13, A** portion of the GF savings achieved from this legislation ~~will be~~ **was** used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 through FY 2006-07.

W 27 (PC-98) X  
(PC-108)  
(PC-112)

### BTR-Health Care Coverage Initiative Rollover Funds

HCCI, one component of BTR, covers individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to an annual cap. The Department received federal approval to reallocate the unspent DY 6, ~~and DY 7,~~ **DY 8, and DY 9** HCCI money to the SNCP uncompensated care component. The reallocated funding to SNCP will be shared 50/50 between DPHs and the State. As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves \$400 million in annual General Fund savings.

W 28 (PC-113) X X  
(PC-FI)

### Diagnosis Related Group – Inpatient Hospital Payment Methodology

SB 853 (Chapter 717, Statutes of 2010) mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon diagnosis related groups (DRGs). The DRG payment methodology ~~will replace~~ **replaces** the previous payment methods. For contract hospitals, DRGs ~~will~~ replace the per diem rates negotiated under the Selective Provider Contracting Program (SPCP). For non-contract hospitals, DRGs ~~will~~ replace

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

the previous cost-based reimbursement methodology. ~~The~~ DRG implementation is scheduled to begin ~~was implemented on~~ July 1, 2013 **for private hospitals and will be implemented on January 1, 2014 for NDPHs.**

The Medi-Cal Fiscal Intermediary, Xerox State Healthcare, LLC (Xerox), ~~will implement~~ **implemented** California Medicaid Management Information Systems (CA-MMIS) changes to comply with this legislation.

W 29 (PC-101) X      X

**Uncompensated Care Payments for Tribal Health Programs**

CMS approved an amendment to the Bridge to Reform Demonstration to make uncompensated care payments for services provided by Indian Health Service (IHS) tribal health programs to IHS eligible individuals with:

- Incomes up to 133% of the FPL, and
- Who are not ~~eligible for~~ **enrolled in** a Low Income Health Program (LIHP).

The demonstration ~~will provide~~ **provides** uncompensated care payments at the IHS encounter rate for Medi-Cal state plan primary care services and other optional services eliminated from the state plan.

For Medi-Cal enrolled IHS eligible individuals, this demonstration ~~will provide~~ **provides** uncompensated care payments only for optional services eliminated from the state plan. The effective date of the demonstration is from April 5, 2013 to December 31, 2013.

Services provided to non-IHS eligible individuals ~~will~~ **are** also ~~be~~ eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements.

For services provided to IHS eligible individuals, reimbursement ~~will be~~ **is** 100% FFP. For services provided to non-IHS eligible individuals, reimbursement ~~will be~~ **is** claimed through certified public expenditures. There will be no GF impact.

**1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y  
W 30 (PC-111) X

Private Hospitals Supplemental Fund Savings

The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased California's FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011.

The Private Hospital Supplemental Fund includes funds received due to the increased ARRA FMAP. In FY 2013-14, the Department will redirect the ARRA funds from the Private Hospital Supplemental Fund to the GF.

## MANAGED CARE

### Medi-Cal Managed Care Rates

Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months and plans' self-reported utilization and encounters by category of service (i.e., Inpatient, ER, Pharmacy, PCP, Specialist, FQHC, etc.) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The delivery events and associated maternity costs are carved out of the Family/Adult, and Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid categories to establish a budget neutral county specific maternity supplemental payment.

Trend studies are performed and policy changes are incorporated into the rates. Medi-Cal specific financial statements are gathered for each plan for the last five quarters. Administrative loads are developed based upon a Two-Plan program average. Plan specific rates are established based upon all of the aforementioned steps.

A financial experience model is developed by trending plan specific financial data to the mid-point of the prospective rate year. The financial experience is then compared to the rate results established through the rate development model. If the result is reasonable, the rates are established from the rate development model. If the result is not reasonable, additional research is performed and the rates are adjusted based upon the research and actuarial judgment.

The maternity supplemental payments are in addition to the health plan's monthly capitation payment and are paid based on the plan's reporting of a delivery event. Maternity supplemental payment amounts are done in a budget neutral manner so that the cost of the expected deliveries does not exceed the total dollars removed from the Adult/Family and Disabled Medi-Cal Only capitation rates.

Capitation rates are risk adjusted to better reflect the match of a plan's expected costs to the plan's risk. Capitation rates are risk adjusted in the Family/Adult and Aged /Disabled/Medi-Cal Only Categories of Aid (COAs).

Risk Adjustment and County Averaging is prepared with plan specific pharmacy data (with NDC Codes) gathered for Managed Care and FFS enrollment data for the most recent 12 month period. A cut-off date is established for the enrollment look-back. If a beneficiary is enrolled for 6 of the 12 months (not consecutively), then the beneficiary is counted in the plan's risk scoring calculation.

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Family/Adult or SPD Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate.

## MANAGED CARE

The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2012-13 ~~2013-14~~ rates, ~~35%~~ **40%** of this county specific rate was taken and multiplied by each plan's respective risk score and ~~65%~~ **60%** of each plan's plan specific rate was retained and added to the ~~35%~~ **40%** risk adjusted rate to establish a risk adjusted plan specific rate. For FY 2013-14 rates, the percentage of county specific rates used in the risk adjustment will increase from 35% to 40% with an additional quality factor of 5%. **The risk adjustment policy will be examined in future years and adjusted if determined necessary.**

For County Organized Health Systems, rates continue to be based on the plans' reported expenditures trended in the same manner as for the Two Plan and GMC models.

### **Fee-for-Service Expenditures for Managed Care Beneficiaries**

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to FQHC/RHC providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

For further information, see policy change FFS Costs for Managed Care Enrollees.

### **2012-13 and 2013-14 Rates**

Overall, the rates represent a ~~0.7%~~ **3.63%** increase in FY 2012-13 ~~FY 2013-14~~ over the previous fiscal year rates (based on a fiscal year comparison). Rates for 2013-14 ~~2014-15~~ represent a ~~3.74%~~ **3.5%** increase over the 2012-13 ~~2013-14~~ fiscal year rates.

**MANAGED CARE: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 1	(PC-114) X	X	<p><u>Two-Plan Model</u></p> <p>Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed or designated managed care health plan referred to as the Local Initiative (LI). The other plan is a non-governmentally operated Health Maintenance Organization referred to as the Commercial Plan (CP). Currently, fourteen counties are fully operational under the Two-Plan Model.</p> <p>Capitation rates include the annual rate redeterminations.</p>
M 2	(PC-115) X (PC-142)	X	<p><u>County Organized Health Systems</u></p> <p>Six County Organized Health Systems (COHSs) are operational in fourteen counties. <del>Effective February 1, 2010, Health Plan of San Mateo added long term care services to their contract.</del> Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries. PHC is negotiating with the Department to remove undocumented beneficiaries from their contract. The Department is currently in discussions with all COHS plans to incorporate 1115 waiver requirements related to Seniors and Persons with Disabilities.</p> <p>Capitation rates include the annual rate redeterminations.</p>
M 3	(PC-116) X	X	<p><u>Geographic Managed Care</u></p> <p>Under the Geographic Managed Care model, counties contract with multiple commercial plans to provide services to beneficiaries. Currently, Sacramento and San Diego counties utilize the geographic managed care model.</p> <p>Capitation rates include the annual rate redeterminations.</p>
M 4	(PC-129) X	X	<p><u>AIDS Healthcare Centers</u></p> <p>Managed Care Organization (MCO): Positive Healthcare Services (dba AIDS Healthcare Centers) is located in Los Angeles.</p> <p>All drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) prior to January 1, 2002 are included in the plan's contracted scope of services except for new</p>

## MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

drugs which do not fit into one of the current therapeutic classes and for which the Department does not have **there is not** sufficient utilization data to determine the financial impact of the use of those drugs will have on the managed care plan. ~~New rates developed effective January 1, 2011, pending CMS approval, include all drugs used to treat HIV/AIDS approved by the FDA prior to January 1, 2007.~~

Savings Sharing/Incentive Distributions: Prior obligations exist for AIDS Healthcare Centers. These are obligations that are owed to the contractor for cost savings created when actual costs are less than FFS equivalent costs. The process of making final determinations of the amount of savings sharing can take up to one year. The Department has determined there will not be a savings sharing for calendar year 2009. Because of the long period of time needed to make the final determinations, savings sharing has not been determined for calendar year 2010 and beyond.

~~On January 1, 2012, the Department entered into a new five-year contract with AHF. On August 2, 2012, AHF received full-risk licensure. Based upon this change in status, the Department will develop a new rate. The rate will not be effective until a new contract is signed.~~

M 5    (PC-130) X    X

### Family Mosaic Capitated Case Management

Located in San Francisco, the Family Mosaic Project case manages emotionally disturbed children and adolescents at risk for out-of-home placement. Enrollment began in June 1993. FMP provides, coordinates, and oversees mental health treatment for children and youth with severe emotional and behavioral problems, targeting children who are at high risk for out-of-home placement or incarceration. FMP uses the capitation payments to provide the required services and also purchase and monitor other services from a network of private providers and community-based organizations in order to keep families together.

The Family Mosaic Project contract with the Department was effective January 1, 2008 through December 31, 2012, and has been extended through June 30, 2014.

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y																																												
		<u>C/Y</u>	<u>B/Y</u>																																											
M 6	(PC-118)	X	X	<u>Managed Care Rate Range Intergovernmental Transfers</u>																																										
<p>Counties will transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds will be used for the nonfederal share of 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.</p> <p><u>The following counties' IGT will continue on an ongoing basis:</u></p> <table border="0"> <thead> <tr> <th><u>COHS</u></th> <th><u>Effective Date of IGT</u></th> </tr> </thead> <tbody> <tr><td>San Mateo</td><td>July 1, 2005</td></tr> <tr><td>Santa Barbara</td><td>July 1, 2009</td></tr> <tr><td>Santa Cruz</td><td>July 1, 2009</td></tr> <tr><td>Solano</td><td>July 1, 2009</td></tr> <tr><td>Monterey</td><td>July 1, 2009</td></tr> <tr><td>Sonoma</td><td>October 1, 2009</td></tr> <tr><td>Merced</td><td>October 1, 2009</td></tr> <tr><td>Orange</td><td>July 1, 2010</td></tr> <tr><td>Yolo</td><td>July 1, 2010</td></tr> <tr><td>Marin</td><td>July 1, 2011</td></tr> </tbody> </table> <table border="0"> <thead> <tr> <th><u>Two Plan Model</u></th> <th><u>Effective Date</u></th> </tr> </thead> <tbody> <tr><td>Los Angeles</td><td>October 1, 2006</td></tr> <tr><td>Alameda</td><td>October 1, 2008</td></tr> <tr><td>Contra Costa</td><td>October 1, 2008</td></tr> <tr><td>Kern</td><td>October 1, 2008</td></tr> <tr><td>Riverside</td><td>October 1, 2008</td></tr> <tr><td>San Bernardino</td><td>October 1, 2008</td></tr> <tr><td>San Francisco</td><td>October 1, 2008</td></tr> <tr><td>San Joaquin</td><td>October 1, 2008</td></tr> <tr><td>Santa Clara</td><td>October 1, 2008</td></tr> </tbody> </table>					<u>COHS</u>	<u>Effective Date of IGT</u>	San Mateo	July 1, 2005	Santa Barbara	July 1, 2009	Santa Cruz	July 1, 2009	Solano	July 1, 2009	Monterey	July 1, 2009	Sonoma	October 1, 2009	Merced	October 1, 2009	Orange	July 1, 2010	Yolo	July 1, 2010	Marin	July 1, 2011	<u>Two Plan Model</u>	<u>Effective Date</u>	Los Angeles	October 1, 2006	Alameda	October 1, 2008	Contra Costa	October 1, 2008	Kern	October 1, 2008	Riverside	October 1, 2008	San Bernardino	October 1, 2008	San Francisco	October 1, 2008	San Joaquin	October 1, 2008	Santa Clara	October 1, 2008
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M 7	(PC-135)	X	X	<u>Managed Care IGT Administrative and Processing Fee</u>																																										
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**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

with FY 2010-11 rate range IGTs processed after July 1, 2011, and all subsequent rate range IGTs occurring after July 1, 2011, the Department will charge counties an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the cost of medical services provided under the Medi-Cal program.

AB 102 (Chapter 29, Statutes of 2011) provides that all IGTs are subject to the fee with the exception of the IGTs related to Designated Public Hospitals (DPHs). If the IGT is replacing the CPE previously claimed in fee-for-service, no fee will be charged.

M 8    (PC-120) X    X

Managed Care Public Hospital IGTs

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage are being assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. In conjunction with this, SB 208 (Chapter 714, Statutes of 2010) allows public entities, such as Designated Public Hospitals (DPH), to transfer funds under Intergovernmental Transfers (IGT) to the Department, pending CMS approval. The funds will be used as the non-federal share of capitation rate increases. This will enable plans to compensate DPHs in amounts that are no less than what they would have received for providing services to these beneficiaries under the FFS model, including supplemental payments, CPEs and any additional federally permissible amounts, which are available only under FFS.

M 9    (PC-136) X    X

General Fund Reimbursements from DPHs

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) are assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. For Medi-Cal beneficiaries under the FFS program, payments to Designated Public Hospitals (DPHs) are comprised of CPEs matched with federal funds. For Medi-Cal beneficiaries under managed care, payments to DPHs are comprised of General Fund and federal funds. Therefore, as SPDs were transitioned into managed care, GF expenditures increased for DPH services.

Beginning in ~~FY 2013-14~~ **June 2013**, DPHs will reimburse the GF for costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 10	(PC-NA)	X	X	<p><u>Increase in Capitation Rates for Gross Premium Tax</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Available" section.</p>
M 11	(PC-NA)	X	X	<p><u>Funding Adjustment of Gross Premium Tax Funds to GF</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Applicable" section.</p>
M 12	(PC-128) (PC-133) (PC-121) (PC-137) (PC-134)	X	X	<p><u>Extend Gross Premium Tax – Increase Capitation Rates</u></p> <p>ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through FY 2011-12. <del>The Administration Department is proposing legislation that would extend</del> <b><u>SB 78 (Chapter 33, Statutes of 2013) extended</u></b> the Gross Premium Tax sunset date on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2013. 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 proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. Managed Care plans affected by this new proposed legislation are:</p> <ul style="list-style-type: none"> <li>• Two Plan Model;</li> <li>• County Organization Health Systems;</li> <li>• Geographic Managed Care;</li> <li>• AIDS Healthcare Centers; and</li> <li>• SCAN.</li> </ul>
M 13	(PC-138)	X	X	<p><u>FFS Costs for Managed Care Enrollees</u></p> <p>Managed care contracts specify that certain services are carved out of the rates paid for managed care enrollees. These services are provided through the fee-for-service system. The most significant carve-outs for most plans are CCS services and anti-psychotic drugs. Additionally, the Department pays federally qualified health care centers and rural health clinics under the fee-for service system for certain costs associated with serving Medi-Cal managed care enrollees which are not fully paid by Medi-Cal managed care plans.</p>

## MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 14	(OA-36)	X	X	<p><u>San Diego County Administrative Activities</u></p> <p>The County of San Diego provides administrative services for the San Diego Geographic Managed Care program. These administrative activities include health care options presentations, explaining the enrollment and disenrollment process, customer assistance, and problem resolution. Federal funding for these activities was discontinued as of August 1, 2003.</p>
M 15	(PC-NA)	X	X	<p><u>Managed Care Cost-Based Reimbursement Clinics (CBRC)</u></p> <p>This assumption has been moved to the "Fully Incorporated Into Base Data/Ongoing" section.</p>
M 16	(PC-NA)	X	X	<p><u>Align Managed Care Benefit Policies</u></p> <p>This assumption has been moved to the "Fully Incorporated Into Base Data/Ongoing" section.</p>
M 17	(PC-123) (PC-143) (PC-197) (PC-119) (OA-17) (PC-FI)	X	X	<p><u>Transition of Dual Eligibles-Long-Term Care Savings</u></p> <p>The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) and other Home and Community-Based Services (HCBS) from fee-for-service into managed care health plans. Notices <b><u>Enrollment notices</u></b> and packets <b><u>managed care guidebooks</u></b> will be mailed to beneficiaries. <b><u>Additional administrative costs will be required when enrolling beneficiaries into managed care health plans.</u></b></p> <p><del>The administrative costs to enroll beneficiaries into the managed care health plans include:</del></p> <ul style="list-style-type: none"> <li><del>• Mailing Medi-Cal and Medicare information,</del></li> <li><del>• Outreach services,</del></li> <li><del>• Rate setting for newly included long term services and supports (LTSS),</del></li> <li><del>• System design and modification needs,</del></li> <li><del>• Medicare and Medi-Cal data collection,</del></li> <li><del>• Development of quality metrics,</del></li> </ul>

## MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				<ul style="list-style-type: none"> <li>• <del>Performance measures for rapid cycle quality improvement and long term quality assurance,</del></li> <li>• <del>Ombudsman services and reporting, and</del></li> <li>• <del>Monitoring by an External Quality Review Organization (EQRO).</del></li> </ul>
M 18	(PC-127) X (PC-FI)		X	<p><u>Managed Care Expansion to Rural Counties</u></p> <p>Managed care is currently in 30 counties. AB 1467 (Chapter 23, Statutes of 2012) 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.</p> <p><b><u>The transition to managed care in the 28 counties will phase in beginning September 1, 2013. There will be three different managed care models in the rural counties — County Organized Health Systems, Regional Models, and voluntary passive enrollment model with the ability to opt out.</u></b></p>
M 19	(PC-NA) X		X	<p><u>Potentially Preventable Admissions</u></p> <p>This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.</p>
M 20	(PC-NA) X			<p><u>Retroactive Managed Care Rate Adjustments for FY 2011-12</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
M 21	(PC-NA) X		X	<p><u>Enrollment Stabilization Program</u></p> <p>This assumption has been moved to the “Discontinued Assumptions: Withdrawn” section.</p>
M 22	(PC-117) X (PC-139) (PC-140) (PC-18) (PC-21)		X	<p><del>Sales</del> <u>MCO Tax on Managed Care Plans</u></p> <p>The Administration has proposed legislation to impose <b>SB 78 (Chapter 33, Statutes of 2013) imposed</b> the statewide sales tax on Medi-Cal managed care plans effective July 1, 2014 <b>July 1, 2013</b>. One half of the proceeds of the tax <del>would</del> <b>will</b> be used to increase rates to the plans to reimburse them for the cost of the</p>

## MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
			tax. The other half of the proceeds <del>would</del> <b>will</b> be used to offset General Fund cost in the Medi-Cal program.
M 23	(PC-124)	X	X
			<u>Retroactive Managed Care Rate Adjustments for FY 2012-13</u>
			Retroactive rate adjustments are due to the rate determinations for the Rate Year 2012-13 for Two Plan, COHS, and GMC. Capitation rate increases for FY 2012-13 will be paid in FY 2013-14.
M 24	(PC-132)		X
			<u>Annual Redetermination of Capitation Rates</u>
			Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends. A placeholder is included in the November estimate until rates are finalized.
<u>M 25</u>	<u>(PC-22)</u>	<u>X</u>	<u>X</u>
			<u><b>Mental Health Services Expansion</b></u>
			<u><b>SBX1 1 (Hernandez, Chapter 4, Statutes of 2013) provides that Medi-Cal managed care plans (MCPs) must provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Waiver. In addition, mental health benefits will include group counseling.</b></u>

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## PROVIDER RATES

### **Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities**

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personnel activities. Costs are limited to the 90th percentile of each facility's peer group.
- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90th percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

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## PROVIDER RATES

### **Quality and Accountability Supplemental Payment Program**

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

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### **Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)**

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

### **Methodology by Type of LTC Facility**

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A ) are peer-grouped by location. Reimbursements are equal to the median of each peer group.

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

## PROVIDER RATES

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. **Effective August 1, 2012**, providers of services to developmentally disabled clients have rates set at the 65<sup>th</sup> percentile of their respective peer groups. **as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65<sup>th</sup> percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65<sup>th</sup> percentile.**

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

**PROVIDER RATES: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
PR 1			<p><u>NF-B Rate Changes and Quality Assurance (QA) Fee</u></p> <p>AB 1629 (Chapter 875, Statutes of 2004) required the Department to change the rate methodology for freestanding skilled nursing facilities (freestanding NF-Bs and freestanding adult subacute facilities, excluding pediatric subacute services and rural swing bed days), to provide an annual cost-of-living adjustment (COLA) and to collect a QA fee from these facilities. Effective January 1, 2012, ABX1 19 (Chapter 4, Statutes of 2011) includes Freestanding Pediatric Subacute facilities within the QA fee provider population. The rate methodology and QA fee provisions sunset on July 31, 2013. <del>AB 1489 (Chapter 631, Statutes of 2012) extends the QA fee, until July 31, 2015.</del></p>
(PC-24)	X	X	<p><u>Rate Changes due to Rate Methodology</u></p> <p>This assumption has been moved to "Provider Rates: AB 1629 Rate Adjustments due to QA Fee" section.</p>
(PC-145) (PC-24)	X	X	<p><del>Rate Adjustments</del> <b><u>AB 1629 Rate Adjustments</u></b> due to QA Fee</p> <p><b><u>AB 1629 (Chapter 875, Statutes of 2004) required the Department to implement a facility specific reimbursement rate for freestanding skilled nursing facilities (NF-Bs) and freestanding adult subacute facilities, collect a Quality Assurance (QA) fee from these facilities, and provide an annual rate adjustment. The annual rate adjustment may vary from year to year, dependent upon legislatively mandated adjustments. A QA fee is collected from (NF-Bs), including adult and pediatric subacute facilities, to offset the GF portion of the reimbursement rates.</u></b></p> <p>Assessment of the QA fee is based on revenues from Medi-Cal, Medicare and private pay sources. Effective October 1, 2011, the QA fee limit increased from 5.5% to 6%.</p> <p>QA fee amounts are calculated to be net of the L&amp;C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. L&amp;C fees shift from year to year, which impacts the amount of QA fee the Department can collect. The State uses a portion of the QA fee to draw down FFP and to fund rate increases <b><u>adjustments</u></b>.</p>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 and 2012-13 rate years, and the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year. A rate adjustment of 0.426% was provided in the 2011-12 rate year. ABX1 19 also extended the QA fees sunset date by one year, to August 1, 2013. AB 1489 (Chapter 631, Statutes of 2012) implemented a rate freeze for the 2012-13 rate year, **provided a 3% rate increase for the 2013-14 and 2014-15 rate years.** and extended the QA fees sunset date to July 31, 2015.

(PC-146) X X

Quality and Accountability Supplemental Payments Program

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability payments program for freestanding nursing facilities (NF-Bs), with the first phase beginning in rate year 2010-11. **The supplemental payments will be tied to demonstrated quality of care improvements.** Quality payments will be delayed a year by AB 1489 (Chapter 631, Statutes of 2012) **requires payments to be made by April 30, 2014.** Payments made under the program will begin in rate year 2013-14 as supplemental to the rates and

**Supplemental payments** will be paid through a special fund **the Skilled Nursing Facility Quality and Accountability Special Fund.** The special fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2013-14 (up to a maximum of 1 % of the overall rate), and the savings achieved from setting the professional liability insurance cost category at the 75th percentile. Per AB 1489 (Chapter 631, Statutes of 2012), the professional liability insurance cost category will still be set at the 75th percentile in 2012-13, but savings will be retained by the state.

(PC-24) X X

AB 1629 Add-Ons

**The following are the add-on rates to AB 1629 facilities:**

CMS mandated that skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. 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

**PROVIDER RATES: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

~~expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. An add-on to the rate was effective August 1, 2011, and retroactive to October 1, 2010.~~

~~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 costs was effective August 1, 2011, and retroactive to October 2009.~~

~~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 August 1, 2012, and retroactive to January 2011. **for the 2013-14 rate year.**~~

~~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 reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to April 2012. **for the 2013-14 rate year.**~~

~~Effective January 2012, CMS requires all health care organizations that submit transactions electronically to upgrade from the Version 4010/4010A to Version 5010 transaction standards. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012 and retroactive to January 2012.~~

~~Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation \$0.02 add-on reimburses enrolled facilities for revalidation costs. This add-on will be effective for 2012-13 rate year.~~

The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on to the rate to reimburse facilities will be effective for ~~2012-13 and~~ **the** 2013-14 rate year.

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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 ~~\$0.04~~ add-on reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and the 2013-14 rate year.

**Under the Patient Protection and Affordable Care Act (ACA), two new fees are assessed on employers providing health insurance, an annual reinsurance fee and a Patient-Centered Outcomes Research Trust Fund Fee (PCORI) per covered life. This add-on will reimburse LTC facilities for compliance costs and will be effective for the 2013-14 and 2014-15 rate years.**

**Under The Patient Protection and Affordable Care Act (ACA) Skilled Nursing Facilities (SNF) are required to implement a compliance and ethics program. This add-on will reimburse LTC facilities for compliance costs and will be effective for the 2013-14 and 2014-15 rate years.**

**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). This add-on will reimburse LTC facilities for compliance costs and be effective for the 2013-14 and 2014-15 rate years.**

PR 2 (PC-157) X X

10% Provider Payment Reduction

AB 97 (Chapter 3, Statutes of 2011) requires the Department to implement a payment reduction of up to 10% to specified providers in FFS, 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 provider payments up to 10%.

The Department received CMS approval on September 11, 2012 to exempt Pediatric Day Health Care providers from the 10% payment reduction, effective April 1, 2012.

**PROVIDER RATES: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The Department submitted a SPA to CMS on December 24, 2012, requesting approval **received CMS approval on August 29, 2013** to exempt audiology services provided by Type C Communication Disorder Centers located in California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco and Sonoma from the 10% payment reduction, effective October ~~1920~~, 2012.

A payment reduction to two Assisted Living Waiver providers, Residential Care Facilities for the Elderly (RCFE) and Care Coordinator Agencies (CCA), was implemented in January 2012. The Department has determined that 1915(c) HCBS waiver providers are not subject to the 10% payment reduction. The Department will refund the reduction amounts and submit a waiver amendment if it is determined that the 10% payment reduction will be applied to these providers.

**On March 31, 2012, the Department submitted a SPA requesting CMS approval to exempt selected drugs and certain pharmacy providers due to access concerns from the 10% payment reduction effective March 31, 2012.**

**The Department will submit a SPA requesting CMS approval to exempt nonprofit dental pediatric surgery centers which provide at least 99% of their services under general anesthesia to children with severe dental disease under the age of 21 from the 10% payment reduction, effective August 31, 2013.**

**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.**

**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**

**Managed care reductions pursuant to AB 97 will be implemented prospectively effective October 1, 2013. Due to**

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

**access concerns, specialty physician services will be exempt from these reductions.**

**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.**

PR 3 (PC-149)	X	X	<p><b><u>Annual MEI Increase for FQHCs and RHCs</u></b></p> <p>The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) included in the 2000 Benefits Improvement and Protection Act on January 1, 2001. Clinics have been given the choice of 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. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the Medicare Economic Index (MEI) and is effective October 1st of each year.</p>
PR 4			<p><b><u>LTC Rate Adjustments and QA Fees</u></b></p>
(PC-148)	X	X	<p><b><u>Rate Adjustment</u></b></p> <p>Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of an annual rate study.</p> <p>The following facilities are included in this assumption:</p> <ul style="list-style-type: none"> <li>• Intermediate Care Facilities/Developmentally Disabled (ICF-DD)</li> <li>• ICF/DD-Habilitative</li> <li>• ICF/DD-Nursing</li> <li>• Freestanding Nursing Facilities – Level A (NF-A)</li> <li>• Distinct Part Nursing Facilities (DP/NF) – Level B</li> <li>• DP/NF Subacute</li> <li>• Pediatric Subacute Care</li> <li>• Rural Swing Beds</li> </ul>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

(PC-152) X X Non-AB 1629 LTC Rate Freeze

ABX4 5 (Chapter 5, Statutes of 2009), froze rates for all LTC facilities for rate year 2009-10 and every year thereafter at the 2008-09 levels.

Under *CHA v. David Maxwell-Jolly*, the Department was enjoined from freezing rates under ABX4 5 for **services rendered on or after February 24, 2010:**

- Distinct Part Nursing Facilities Level B (DP/NF-B)
- DP/NF adult
- DP pediatric subacute
- Rural swing bed providers.

The following facilities were not part of the lawsuit, and their rates continue to be frozen:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A),
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), including Habilitative and Nursing
- FS pediatric subacute facilities

AB 97 (Chapter 3, Statutes of 2011) requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5.

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.**

Currently the following long-term care providers are subject to the rate freeze:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A)
- DP/NF-B
- Rural Swing Bed

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

- Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing
- FS pediatric subacute facilities

### The Department will submit a SPA 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 rated 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 rated as required by AB 97, effective October 1, 2013.

(PC-155) X X 10% Payment Reduction for LTC Facilities

AB 97 (Chapter 3, Statutes of 2011) also required the Department to reduce payments to long-term care facilities by up to 10% in FFS, effective June 1, 2011. The actuarial equivalent of that amount in managed care 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. ~~Subsequently, ABX1-19 (Chapter 4, Statutes of 2011) requires the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% of rate year 2008-09 rates.~~

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.** DP/NF adult subacute, DP and FS pediatric subacute, rural swing bed, NF-A, and ICF/DD (including Habilitative and Nursing) facilities were not part of the lawsuit.

The following long-term care providers are not subject to the 10% payment reduction:

- Distinct Part Adult Subacute Facilities
- Distinct Part Pediatric Subacute Facilities
- Hospice Providers

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Hospice Room and Board Providers
- Rural Swing Bed Rate

The following long-term care providers are subject to the 10% payment reduction:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A)
- Distinct Part Nursing Facilities, Level B
- Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), including Habilitative and Nursing – The Department recently submitted a request to CMS to modify the rate-setting methodology, which will result in reduced rates of up to 10% for some facilities. **On February 27, 2013, CMS approved the revised rate-setting methodology, retroactive to August 1, 2012. The Department will utilize this methodology for the rate-year commencing August 1, 2013.**

**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 rated 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 rated as required by AB 97, effective October 1, 2013.**

**Due to access concerns, the Department will forgo the retroactive recoupment for ICF DDs**

(PC-148) X    X

### QA Fees

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) and Freestanding Pediatric Subacute Care facilities are required to pay a QA fee. The federal government allows states to assess the QA fee at 6% of total gross revenues. The fee is used to draw down FFP and fund rate increases, which are expected to be cost neutral to the GF.

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
(PC-148)	X	X	<u>Non-AB 1629 Add-Ons to the Rates</u>

### **The following are the add-on rates to Non-AB 1629 facilities:**

- CMS mandated that freestanding and distinct part skilled nursing facilities, nursing facilities-level A, including Adult and Pediatric Subacute, upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. 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, and retroactive to October 1, 2010.
- 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 costs was effective August 1, 2011, and retroactive to October 2009.
- 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.
- 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 reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to April 2012.
- ~~Effective January 2012, CMS requires all health care organizations that submit transactions electronically to upgrade from Version 4010/4010A to Version 5010 transaction standards. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012 and retroactive to January 2012.~~
- ~~Effective July 1, 2010, SB 183 (Chapter 19, Statutes of 2010), the Carbon Monoxide Poisoning Prevention Act, requires~~

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

~~single-family dwelling units to have installed a carbon monoxide device that is designed to detect carbon monoxide and produce a distinct, audible alarm, which must be approved by the State Fire Marshal. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to July 2011. This add-on is only applicable to ICF/DD Hs and Ns.~~

- 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. An add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
- The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
- ~~Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation add-on reimburses enrolled facilities for revalidation costs. This add-on will be effective for 2012-13 rate year excluding ICF/DD, ICF/DD-H and ICF/DD-N.~~
- 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 reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.
- **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.**
- **Effective March 23, 2013, the Patient Protection and Affordable Care Act (ACA) requires Skilled Nursing and Nursing Facilities to implement a compliance and ethics program. An add-on will be provided to cover costs associated with implementing this program and will be**

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

**effective for the 2013-14 and 2014-15 rate years excluding ICF/DD, ICF/DD-H and ICF/DD-N facilities.**

- **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). An 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.**

PR 5 (PC-150) X X

### Hospice Rate Increases

Pursuant to state regulations, Medicaid hospice rates are established in accordance with 1902(a)(13), (42 USC 1396a(a)(13)) of the federal Social Security Act. This act requires annual increases in payment rates for hospice care services based on corresponding Medicare rates. New hospice rates are effective October 1st of each year.

Effective February 1, 2003, hospice room and board providers are reimbursed at 95% of the Medi-Cal per-diem rate paid to the facility with which the hospice is affiliated. This change in reimbursement methodology was made to reflect the CMS allowable rate, in accordance with 42 USC 1396a(a)(13)(B) and 1902(9a)(13)(B) of the federal Social Security Act.

PR 6 (PC-BA) X X

### Alternative Birthing Centers

Pursuant to W & I Code Section 14148.8, the Department is required to provide Medi-Cal reimbursement to alternative birthing centers (ABCs) for facility-related costs at a statewide all-inclusive rate per delivery. This reimbursement must not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts. The reimbursement rates must be updated annually and must be based on an average hospital length of stay of 1.7 days. The ABC rates will increase **change** each year by the same percentage as the average acute care hospital contract rate. ~~Effective July 1, 2013, rates will increase each year by the same percentage as the average~~ **increase change** in Diagnosis Related Groups base prices, **if there is a change.**

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PR 7 (PC-156)	X	X	<p><u>Reduction to Radiology Rates</u></p> <p>SB 853 (Chapter 717, Statutes of 2010) reduced Medi-Cal rates for radiology services to 80% of Medicare rates, effective October 1, 2010. It is expected that the rate methodology will be implemented in July <b>December</b> 2013 with rate reductions retroactive to July 1, 2012 in order to protect beneficiary access to needed radiology services.</p>
PR 8 (PC-147)	X	X	<p><u>Air Ambulance Medical Transportation</u></p> <p>AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 upon every conviction involving a vehicle violation, 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.</p> <p>AB 215 (Chapter 392, Statutes of 2011) removed a county's ability to retain a portion of moneys collected from the penalties to administer the EMATA and deletes the requirement that counties submit an annual report to the Department on the funds the county retained for administration costs.</p> <p>After the payment of the Department's administrative costs, 20% of the fund will be allocated to the General Fund. The remaining 80% in the EMATA fund will be matched with federal funds and will be used to increase payments for Medi-Cal emergency air medical transportation services.</p> <p>The Department submitted two SPAs to CMS:</p> <ul style="list-style-type: none"> <li>• SPA 12-001A, approved by CMS in November 2012, allows the Department to disburse the EMATA funds to air medical transportation providers in lump sum supplemental payments on a per transport basis for services provided between January 7, 2012 and June 30, 2012.</li> <li>• SPA 12-001B, pending CMS approval, allows the Department to implement ongoing payment augmentations for services provided by air medical transportation providers retroactive to July 1, 2012.</li> </ul>

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
PR 9 (PC-NA)	X	X	<p><u>10% Payment Reduction Restoration and Supplemental Payments</u></p> <p>This assumption has been moved to the “Timed Limited/No Longer Available” section.</p>
PR 10 (PC-NA)	X	X	<p><u>Eliminate 2012-13 Rate Increase &amp; Supp. Payment</u></p> <p>This assumption has been moved to the “Timed Limited/No Longer Available” section.</p>
PR 11 (PC-154)	X	X	<p><u>Laboratory Rate Methodology Change</u></p> <p>AB 1494 (Chapter 28, Statutes of 2012) allows the Department to develop a new rate methodology for clinical laboratory and laboratory services. In addition to 10% payment reductions implemented pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allows payments to be reduced by an additional 10% 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 CMS. <b><u>CMS is reviewing a SPA requesting approval for the additional 10% reduction. The Department will submit a subsequent SPA to CMS for the proposed rate methodology changes with a proposed implementation date of April 1, 2014.</u></b> The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.</p>
PR 12 (PC-151)	X	X	<p><u>Long Term Care Quality Assurance Fund Expenditures</u></p> <p>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 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.</p> <ul style="list-style-type: none"> <li>• Freestanding Nursing Facilities Level-B (FS/NF-Bs)</li> <li>• Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)</li> </ul>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance Fund. 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.

**SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
SP 1 (PC-165)	X		X
			<u>Capital Project Debt Reimbursement</u>
			<p>SB 2665 (Chapter 1310, Statutes of 1990) and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the W&amp;I Code.</p> <p>The SPCP contracts will end on June 30, 2013, due to the implementation of the DRG payment methodology. A SPA is being drafted to obtain authority to continue these payments and will be submitted to CMS in FY <del>2012-13</del> <b>2013-14</b>. Only hospitals that met eligibility requirements set forth in Section 14085.5 of the W&amp;I Code will be eligible to participate.</p> <p>SB 1128 (Chapter 757, Statutes of 1999) authorizes a Distinct Part (DP) 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 must meet other specific hospital and project conditions specified in Section 14105.26 of the W&amp;I Code. Two DP facilities began submitting claims and received payments in FY 2011-12.</p>
SP 2 (PC-162)	X		X
			<u>Hospital Outpatient Supplemental Payments</u>
			<p>AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, 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 share used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. Interim payments are expected to be made every year in June. Interim payment adjustments are made upon receipt and review of amended claims.</p> <p>The reconciliation mandated by AB 915 against audited cost reports is scheduled to begin in FY <del>2012-13</del> <b>2013-14</b>. Adjustments to interim payments, or recoupment of overpaid funds, are expected during FY <del>2012-13</del> <b>2013-14</b>. Reconciliation</p>

## SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.
SP 3 (PC-167)	X		X	<u>IGT Payments for Hospital Services</u>
				W&I Code, Section 14164, 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. The IGT will be used as the non-federal share of cost in order to draw down FFP, which will then be distributed to the hospitals designated by the county or health care district.
SP 4 (PC-166)	X		X	<u>FFP for Local Trauma Centers</u>
				The Budget Act of 2003 provided authority for Los Angeles County and Alameda County to submit IGTs to the Medi-Cal program to be used as the non-federal share of costs in order to draw down federal funds. The combined funds will be used to reimburse specified hospitals for costs of trauma care provided to Medi-Cal beneficiaries.
SP 5 (PC-164)	X		X	<u>Certification Payments for DP-NFs</u>
				AB 430 (Chapter 171, Statutes of 2001) allows Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals to claim FFP on the difference between their projected costs based on the hospital's prior year data and the maximum DP-NF rate Medi-Cal currently pays. The acute care hospitals must be owned and operated by a public entity, such as a city, county, or health care district.
				CMS approved the SPA allowing eligible DP-NFs to claim FFP on the difference between their actual costs and the maximum DP-NF rate Medi-Cal currently pays, effective August 1, 2012. The actual costs are derived from the hospital's as-filed or audited cost report for the reporting year.
				<b><u>AB 97 authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services Distinct Part Nursing Facilities-Level B providers render on or after June 1, 2011. This payment reduction/freeze will increase the uncompensated costs eligible for supplemental reimbursement under this program.</u></b>

## SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
SP 6 (PC-168)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient DSH</u></p> <p>SB 2563 (Chapter 976, Statutes of 1988) created a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible DSH providers on a quarterly basis through a Payment Action Notice (PAN) to the Fiscal Intermediary (FI). The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 7 (PC-169)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient SRH</u></p> <p>AB 2617 (Chapter 158, Statutes of 2000) requires the Department to increase reimbursement rates for outpatient services rendered to Medi-Cal beneficiaries by small and rural hospitals (SRH). The Department reimburses eligible SRH providers on a quarterly basis through a PAN to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 8 (PC-160)	X	X	<p><u>Freestanding Outpatient Clinics</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds eligible freestanding outpatient clinics to the current Medi-Cal outpatient supplemental program. Under this program, 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.</p> <p>The non-federal match is paid from public funds of the participating facilities.</p> <p>Supplemental payments to freestanding outpatient clinics will be effective retroactively beginning <del>July 1, 2006</del> <b><u>October 14, 2006</u></b>. The SPA for freestanding outpatient clinics was approved <del>October 14, 2012</del> <b><u>August 8, 2012</u></b>.</p>
SP 9 (PC-170)	X	X	<p><u>State Veterans' Home Supplemental Payments</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds state veterans' homes to the current Medi-Cal outpatient supplemental program. State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the State are eligible to receive supplemental payments. The non-federal match is paid from</p>

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			public funds of the participating facilities. The SPA for state veterans' homes was approved March 3, 2011.
SP 10(PC-71)	X	X	<u>Specialty Mental Health Services Supplemental Reimbursement</u>
			This assumption has been moved to the "Mental Health" section.
SP 11(PC-163)	X	X	<u>NDPH IGT Supplemental Payments</u>
			AB 113 (Chapter 20, Statutes of 2011) establishes a supplemental payment program for Non-Designated Public Hospitals (NDPHs). These payments are funded with Intergovernmental Transfers (IGTs) and are distributed to the NDPHs based upon a formula in the statute. The State retains nine percent of the IGTs to fund administrative costs and Medi-Cal children's health programs.
SP 12(PC-158)	X		<u>Hospital QAF – Hospital Payments</u>
			AB 1383 (Chapter 627, Statutes of 2009) 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:
			<ul style="list-style-type: none"> <li>• Altering the methodology, timing, and frequency of supplemental payments,</li> <li>• Increasing capitation payments to Medi-Cal managed health care plans, and</li> <li>• Increasing payments to mental health plans.</li> </ul>
			AB 188 (Chapter 645, Statutes of 2009) established the Hospital Quality Assurance Revenue Fund to:
			<ul style="list-style-type: none"> <li>• Provide supplemental payments to hospitals,</li> <li>• Provide direct grants to DPHs,</li> <li>• Increase capitation payments to managed health care,</li> <li>• Increase payments to mental health plans,</li> <li>• Offset the state cost of providing health care coverage for children, and</li> <li>• Pay for staff and related administrative expenses required to implement the QAF program.</li> </ul>

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

SB 90 (Chapter 19, Statutes of 2011) 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 (Chapter 286, Statutes of 2011) 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 (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,
- 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 (Chapter 452, Statutes of 2012) revised the amount of fees paid in the QAF program, supplemental payments and grant amounts paid to hospitals authorized in SB 335.**

SP 13(PC-93)    X

LIHP MCE Out-of-Network Emergency Care Services Fund

SB 335 creates the Low Income Health Program Out-of-Network Medi-Cal Expansion Emergency Care Services Fund (LIHP Fund) to pay for emergency care services to LIHP beneficiaries at out-of-network hospitals. Annually, IGTs from designated public hospitals and funds from the Hospital Quality Assurance Revenue Fund will be paid to out-of-network hospitals.

SP 14(PC-161)    X    X

GEMT Supplemental Payment Program

AB 678 (Chapter 397, Statutes of 2011) provides supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers. Supplemental payments combined with other reimbursements cannot exceed 100% of the costs. Governmental entities provide the non-federal share through CPEs. ~~Once the SPA is approved by CMS, the~~ **The** supplemental reimbursement program will be retroactive to January 30, 2010. ~~The SPA is expected to be~~ was approved in FY 2012-13 **on September 4, 2013.**

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**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
SP 15 (PC-195)	X	X	<p><u>Hospital QAF – Children’s Health Care</u></p> <p>SB 335 (Chapter 286, Statutes of 2011) extended the Hospital QAF program from July 1, 2011 through December 31, 2013, which will provide 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. AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children’s health care coverage.</p>
SP 16 (PC-198) (PC-159)	X	X	<p><u>Extend Hospital QAF</u></p> <p>The current Hospital QAF program will end on December 31, 2013. <del>The Department proposes to extend the program from January 1, 2014 through December 31, 2016.</del> <b><u>The Department is working with stakeholders and the Legislature to implement a new fee program effective January 1, 2014. The new program’s sunset date will be December 2016.</u></b></p>

**OTHER: AUDITS AND LAWSUITS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

A 1 (PC-189) <u>Lawsuits/Claims*</u>	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
a. <u>Attorney Fees of \$5,000 or Less</u>		
1. Faucher, Douglas M.	\$5,000	
Total	\$5,000	
Fund Balance \$45,000	\$50,000	\$50,000
b. <u>Provider Settlements of \$75,000 or Less</u>		
1. CHA Hollywood Medical Center, LP	\$2,907	
2. Catholic Healthcare West.	\$8,860	
3. Little Company of Mary Health Services	\$1,839	
4. Providence Health System-Southern CA	\$24,370	
5. Catholic Healthcare West	\$2,601	
6. Alta Hospitals System	\$22,546	
7. Fresno Community Hospital	\$15,203	
8. Alta Hospitals System	\$14,367	
9. Catholic Healthcare West	\$10,121	
10. Alta Hospitals System	\$3,565	
11. Lifehouse, Inc.	\$9,324	
12. Garden Regional Hospital and Med Ctr.	\$13,696	
Total	\$129,401	
Fund Balance \$1,470,599	\$1,600,000	\$1,600,000
c. <u>Beneficiary Settlements of \$2,000 or Less</u>		
1. Ledezma, Chang, Chikanov, Yu	\$1,438	
Total	\$1,438	
Fund Balance \$13,562	\$15,000	\$15,000
d. <u>Small Claims Court Judgments of \$5,000 or Less</u>		
1. Daughters of Charity Health System	\$142	
2. Faucher, Douglas M.	\$1,073	
Total	\$1,215	
Fund Balance \$198,785	\$200,000	\$200,000
e. <u>Other Attorney Fees</u>		
1. Slote & Link	\$7,500	
2. San Francisco Unified School District	\$220,000	
3. Ledezma, Chang, Chikanov, Yu	\$200,000	
4. Legal Aid Foundation of Los Angeles	\$47,440	
Total	\$474,940	

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

f.	<u>Other Provider Settlements / Judgments</u>		
	Total		\$0
g.	<u>Other Beneficiary Settlements</u>		
	Winton and Geraldine O'Neill		\$17,000
	Victims Compensation Board		<u>\$139,000</u>
	Total		\$156,000

Amounts may exclude interest payments.

A 2	(PC-131)	X	X	<u>Notices of Dispute / Administrative Appeals – Settlements</u>
				Settlement agreements for disputes between the Department and the managed care plans are estimated to be \$2,000,000 for possible settlements for each fiscal year.
A 3	(OA-16)	X	X	<u>Litigation-Related Services</u>
				The Department continues to experience significant and increasing litigation costs in defense of the Medi-Cal program. The number of open cases has increased, and the Department of Justice rates for litigating these cases have increased.
				Ongoing litigation filed by managed care plans against the Department regarding their capitation rates has resulted in increased work and costs for the Department's consulting actuaries to comply with the requirements of the court rulings.
A 4	(PC-58)	X		<u>Litigation Settlements</u>
				The Department continues to work collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks, overcharging, and overpayments. Settlements are expected to be received in FY <del>2012-13</del> <b>2013-14</b> from <b><u>ISTA Pharmaceuticals; Kmart Corp.; Medtronic; Pacific Health Corporation; Pfizer, Inc.; Ranbaxy USA, Inc.; Sanofi-Aventis U.S., Inc.; Johnson &amp; Johnson; Johnson &amp; Johnson (Omincare); Victory Pharma; Seaclyff Diagnostics Medical Group; Serono; Merck; Maxim; GlaxoSmithKline, LLC; Bioscrip; Boehringer Ingelheim Pharmaceuticals, Inc.; McKesson; A-Med Pharmacy; Dava Pharmaceuticals, Inc.; Walgreen's Pharmacy; Senior Care Action Network; KV Pharmaceuticals; Amgen II; and Bio-Med Plus.</u></b>

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

A 5 (PC-196) X X

AB 97 Injunctions

The U.S. District Court, Central District of California, issued a preliminary injunction in the following cases related to AB 97:

- December 28, 2011 – *California Hospital Association v. Douglas, et al.*: The Department was prohibited from implementing the rate freeze and 10% reduction for hospital-based nursing facilities. On March 8, 2012, the district court issued an order modifying the injunction to allow the Department to apply the rate freeze and 10% reduction to services rendered June 1, 2011 through December 27, 2011 that were not reimbursed prior to December 28, 2011 at the unreduced level.
- December 28, 2011 – *Managed Pharmacy Care, et al. v. Sebelius, et al.*: The Department was prohibited 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.
- January 10, 2012 – *California Medical Transportation Association v. Douglas, et al.*: The Department was prohibited from implementing the 10% payment reduction for non-emergency medical transportation (NEMT) providers. The court subsequently modified the injunction to allow DHCS to implement the 10 percent 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
- January 31, 2012 – *California Medical Association v. Douglas, et al.*: The Department was prohibited from implementing a 10% payment reduction 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.

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

On December 13, 2012, the United States Court of Appeals for the Ninth Circuit issued a decision in which it reversed the injunctions against the AB 97 payment reductions issued in all four of the above cases. The plaintiffs requested a rehearing on January 28, 2013. **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 AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

A 6 (PC-187) X X

Audit Settlements

Federal audits A-09-11-02040 and A-09-12-02077 determined that several claims from October 1, 2008 through September 30, 2010 in San Diego County were ineligible for 90% federal Medicaid reimbursement for family planning services provided under the Family PACT program. The audit identified that the majority of the ineligible claims were for primarily non-family planning services. The Department plans to refund the federal government in FY 2013-14.

**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.**

**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.**

**OTHER REIMBURSEMENTS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

R 0.1 (PC-186)X

Reimbursement for IHS/MOA 638 Clinics

The Department will provide reimbursement to Indian Health Services/Memorandum of Agreement 638 clinics that did not receive the full federal per visit rate. The reimbursement for these clinics is for procedure code 02 services provided to Medicare/Medi-Cal beneficiaries between calendar years 2009 through 2012.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 1	(PC-NA)	X	X	<u>FMAP Changes</u>
<p>The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004.</p> <p>On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period.</p> <p>On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act of 2010 that included a six-month extension through June 2011 of Medicaid's temporary enhanced FMAP for the states. California received an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date payment occurs, there will be some expenditures made in FY 2011-12 that receive ARRA. Expenditures may receive the applicable FMAP based on date of service, such as SNCP payments, or based on the date another department paid the initial expenditure and Medi-Cal draws the federal funds in a subsequent fiscal year.</p>				
R 2	(PC-175)	X	X	<u>Dental Contract</u>
<p>The dental rates are based on historical cost data and updated once a year.</p> <p>AB 97 requires a 10% provider payment reduction. CMS approved the reduction, effective June 1, 2011. The current rates remain in effect until the new rates, reflecting the reduction, are negotiated and approved by control agencies through the change order process.</p>				

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 3	(PC-125) (PC-153)	X	X	<p><u>Dental Geographic Managed Care</u></p> <p>The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid codes and SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through several dental plans.</p> <p><del>The Request for Proposal process for a new contract, effective January 1, 2013, began in January 2012.</del> In October 2012, the Department awarded contracts to <b>three</b> GMC dental plans, which took effect on January 1, 2013.</p>
R 4	(PC-125) (PC-153)	X	X	<p><u>Dental Managed Care within Medi-Cal Two-Plan Model Counties</u></p> <p>The 1997-98 Budget Act made a provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis.</p> <p>The Department <del>Department's</del> <del>has contracted</del> <b>contracts</b> with six dental plans that <del>are providing</del> <b>provided</b> services as voluntary PHPs in Los Angeles County; <del>and</del> <b>ended</b> on June 30, 2013. <del>The Request for Proposal process for a new contract began in January 2012.</del> In October 2012, the Department awarded <b>new</b> contracts to <b>three</b> PHP dental plans, which <del>take</del> <b>took</b> effect on July 1, 2013.</p>
R 5	(PC-NA)	X	X	<p><u>FI Cost Containment Projects – Program Savings</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
R 6	(OA-15)	X	X	<p><u>MIS/DSS Contract</u></p> <p>The Management Information System and Decision Support System (MIS/DSS) houses a variety of data and incorporates it into an integrated, knowledge-based system. It is used by the Department, including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance, the Third Party Liability and Recovery Division in its collection efforts, and the Audits and Investigations Division in its anti-fraud efforts.</p> <p>Ongoing operation and maintenance of the MIS/DSS is accomplished through a multi-year contract with Optum</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				Government Solutions, Inc. (formerly Integris, Inc. DBA OptumInsight), which is effective through February 14, 2014. The Department plans to continue contracting for MIS/DSS services after February 14, 2014. <b><u>The Department plans to extend the current MIS/DSS contract to continue services to June 30, 2015. The extension would allow sufficient time to release a Request for Proposal (RFP) that calls for a competitive procurement of services.</u></b>
R 7	(PC-191)	X	X	<p><u>Indian Health Services</u></p> <p>The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and 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 <i>Federal Register</i>.</p>
R 8	(OA-73)	X	X	<p><u>Kit for New Parents</u></p> <p>Beginning in November 2001, Title XIX FFP has been claimed for the "Welcome Kits" distributed by the California Children and Families Commission (Proposition 10) to parents of Medi-Cal eligible newborns.</p>
R 9	(PC-176)	X	X	<p><u>Developmental Centers/State Operated Small Facilities</u></p> <p>The Medi-Cal budget includes the estimated federal fund cost of the CDDS Developmental Centers (DCs) and two State-operated small facilities.</p>
R 10	(OA-63)	X	X	<p><u>CDDS Administrative Costs</u></p> <p>The Medi-Cal budget includes FFP for CDDS Medi-Cal-related administrative costs. Beginning in FY 2001-02, CDDS began budgeting the General Fund in its own departmental budget.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 11 (PC-190) (OA-68)	X	X	<p><u>CLPP Case Management Services</u></p> <p>The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.</p>
R 12 (PC-192)	X	X	<p><u>Cigarette and Tobacco Products Surtax Funds</u></p> <p>Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the <i>Orthopaedic Hospital</i> settlement and Medi-Cal hospital outpatient services via the Hospital Services Account and the Unallocated Account. The amounts available to Medi-Cal vary from year to year.</p>
R 13 (OA-76)	X	X	<p><u>California Health and Human Services Agency HIPAA Funding</u></p> <p>A Health Insurance Portability and Accountability Act (HIPAA) office has been established at the California Health and Human Services Agency to coordinate implementation and set policy regulations for departments utilizing Title XIX programs. Title XIX FFP is available for qualifying HIPAA activities related to Medi-Cal.</p>
R 14 (OA-6)	X	X	<p><u>EPSDT Case Management</u></p> <p>Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.</p>
R 15 (OA-2) (OA-52)	X	X	<p><u>CCS Case Management</u></p> <p>Medi-Cal provides funding for the county administration of the California Children's Services (CCS) Program for those children who receive CCS services who are Medi-Cal eligible. The CMS Net automated eligibility, case management, and service authorization system is used by the CCS program to provide administrative case management for CCS clients in the CCS Medi-Cal, CCS State Only, and CCS-Healthy Families programs.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				<p>The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate.</p> <p>County funds expended above the allocations on administrative activities in support of a county's CCS/Medi-Cal caseload may be used as certified public expenditures to draw down Title XIX federal financial participation.</p>
R 16	(OA-41)	X	X	<p><u>Postage and Printing – Third Party Liability</u></p> <p>The Department uses direct mail and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms/questionnaires printed and mailed and report information received correlates to the Medi Cal caseload.</p>
R 17	(OA-53)	X	X	<p><u>TAR Postage</u></p> <p>Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.</p>
R 18	(PC-188)	X	X	<p><u>HIPP Premium Payouts</u></p> <p>The Department pays the premium cost of private health insurance for high-risk beneficiaries under the Health Insurance Premium Payment (HIPP) program when payment of such premiums is cost effective.</p>
R 19	(PC-172)	X	X	<p><u>Medicare Part A and Part B Buy-In</u></p> <p>The Department pays CMS for Medicare Part A (inpatient services) and Part B (medical services) premiums for those Medi-Cal beneficiaries who are also eligible for Medicare. Part B beneficiaries with an unmet share of cost are not eligible.</p> <p>These premiums allow Medi-Cal beneficiaries to be covered by Medicare for their cost of services, thus saving Medi-Cal these expenditures. The premium amounts are set by CMS effective January 1st of each year.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 20 (OA-79)	X	X	<p><u>PIA Eyewear Courier Service</u></p> <p>The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the costs of the courier service that delivers orders between the optical providers and PIA.</p>
R 21 (OA-67)	X	X	<p><u>FFP for Department of Public Health Support Costs</u></p> <p>Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs are budgeted in the Medi-Cal local assistance budget and are shown as a reimbursement in the CDPH budget.</p>
R 22 (PC-178)	X	X	<p><u>ICF-DD Transportation and Day Care Costs - CDDS</u></p> <p>Beneficiaries that reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) also receive active treatment services from providers located off-site from the ICF/DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.</p> <p>On April 15, 2011, CMS approved a SPA that allows FFP to be paid for these services retroactive back to July 1, 2007.</p>
R 23 (PC-183)	X	X	<p><u>Non-Contract Hospital Inpatient Cost Settlements</u></p> <p>All non-contract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the non-contract 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.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 24	(PC-144)	X	X	<u>FQHC/RHC/CBRC Reconciliation Process</u>
<p>The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics and Cost-Based Reimbursement Clinics (FQHC/RHC/CBRCs) participating in the Medi-Cal PPS is applied as follows:</p> <p>Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in managed care plans or dual eligible beneficiaries, an interim rate is established in order for the clinic to be reimbursed the difference between the Medi-Cal PPS rate and the payments received from managed care plans and Medicare. There is no established interim rate for CHDP visits.</p> <p>The difference between the interim rate and the payments from managed care plans and Medicare, and the difference between the PPS rate and the payments from CHDP, is reconciled by an annual reconciliation request that is filed by each FQHC/RHC within five months of the close of their fiscal period.</p> <p>A tentative settlement is prepared by the Department after review of the reconciliation request. Within three years after the date of submission of the original reconciliation report, as required by W &amp; I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared.</p> <p>W &amp; I Code § 14105.24 requires the Department to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. An interim rate, adjusted after each audit report is final, is paid to the clinics. The CBRCs are then required to submit an annual cost report no later than 150 days after the close of their fiscal year. The Department audits each CBRC's cost report and completes a cost settlement which results in a payment to the CBRC or a recoupment from the CBRC. The Department expects to complete audits and adjust interim rates each fiscal year to the appropriate audited levels.</p>				
R 25	(OA-30)	X	X	<u>HIPAA Capitation Payment Reporting System</u>
<p><del>Prior to the HIPAA Capitation Payment Reporting System (CAPMAN), the Department paid contracted managed care health plans through a manual process. The manual process limited the</del></p>				

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

~~reporting of capitation amounts at the aid code level or above. HIPAA mandates that the Department report these types of payments with a standard HIPAA transaction. The Department implemented the new HIPAA transaction requirements on July 1, 2011.~~

The new HIPAA transaction requirements (5010):

- ~~• Make significant improvements to the capitation calculation process,~~
- ~~• Allow detailed reporting at the beneficiary level,~~
- ~~• Increase the effectiveness of monthly reconciliation between Medi-Cal and the contracted managed care plans, and~~
- ~~• Support research efforts to perform recoveries.~~

**The Department implemented the CAPMAN system in July 2011. The HIPAA compliant transaction automated and improved the capitation calculation process. The CAPMAN system:**

- **Allows detailed reporting at the beneficiary level,**
- **Increases the effectiveness of monthly reconciliation between Medi-Cal and the contracted managed care plans, and**
- **Supports research efforts to perform recoveries.**

Due to the **Affordable Care Act and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to prepare for the influx of new beneficiaries. Modifications will be made to further enhance the system to incorporate a paperless accounting interface and accommodate the CCI Duals Demonstration project. The system will have to be maintained on an ongoing basis, as new functionality is required.** ~~The Department anticipates that a new five-year contract is required to bring vendor staff to work with the Department on CAPMAN system changes **A new five-year contract was executed in July 2013 to address these system changes.**~~

R 26 (OA-11) X    X  
 (PC-177)  
 (PC-FI)

ARRA HITECH Incentive Program

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of ARRA of 2009, authorizes federal funds for Medicare and Medicaid incentive programs from

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

2011 through 2021. To qualify, health care providers must adopt, implement or upgrade (AIU), and meaningfully use (MU) Electronic Health Records (EHR) in accordance with the HITECH Act. The HITECH Act pays provider incentive payments at 100% Federal Financial Participation (FFP).

The Department received approval of the State Medicaid Health Information Technology Plan (SMHP) and Implementation Advance Planning Document (IAPD) on September 30, 2011. The SMHP and IAPD authorized implementation of the EHR Incentive Program, which occurred on October 3, 2011. CMS approved an IAPD Update (IAPD-U) on December 11, 2012. The authorization provides additional funds for MU measures specific to immunization registries.

The Medical Fiscal Intermediary (FI) began implementing a system necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive Program. The Department anticipates the incentive payments will accelerate the AIU and MU of certified EHR technology.

The Department plans to expand the current Medicaid Management Information System (MMIS) to integrate a State Level Registry (SLR) payment functionality, allowing for more seamless and efficient participation and payment for eligible ~~providers (EPs)~~ **professionals (EPs) and eligible hospitals (EHs)**.

CMS requires the Department to assess the usage of and barriers to AIU and MU by EPs **provider type**; the assessments require multiple contractors.

The HITECH Act of 2009 allows a 90/10 FFP for administrative activities. The enhanced funding supports further advancement and maintenance of the EHR program.

R 27 (OA-38) X X

**Encryption of PHI Data**

The Department acquired hardware, supplies and associated maintenance and support services that are necessary to encrypt electronic data stored on backup tapes. The data on these tapes contain Medi-Cal beneficiary information that is considered confidential and/or protected health information (PHI) by federal and state mandates.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The encryption of these tapes will:

- Secure and protect Department information assets from unauthorized disclosure,
- Protect the privacy of Medi-Cal beneficiaries,
- Prevent lawsuits from citizens for privacy violations,
- Avoid costs to notify millions of people if a large breach does occur, and
- Maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

R 28 (PC-185) X    X

ICF-DD Administrative and QA Fee Reimbursement - CDDS

The Department of Developmental Services (DDS) will make supplemental payments to Medi-Cal providers that are licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), ICD-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center consumers. The services and transportation are arranged for and paid by the local Regional Centers, which will bill DDS on behalf of the ICF-DDs. A State Plan Amendment (SPA) was approved April 15, 2011. DDS will provide payment, retroactive to July 1, 2007, to the ICF-DDs for the cost of reimbursing the Regional Centers for the cost of arranging the services plus a coordination fee (administration fee and the increase in the QA fee).

On April 8, 2011, the Department entered into an interagency agreement with DDS for the reimbursement of the increased administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

R 29 (PC-194) X    X

CLPP Fund

Medi-Cal provides blood lead tests to children who are at risk for lead poisoning and are full-scope Medi-Cal beneficiaries or are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program. The CHDP State-Only program provides lead screenings to Medi-Cal beneficiaries who are eligible for emergency and pregnancy related services. The lead tests are funded by the CLPP Fund which receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

			Equalization. The expenditures for the lead testing are in Medi-Cal's FFS base trends and this policy change adjusts the funding.
R 30	(PC-127) X (PC-143)		<p><u>Payment Deferral</u> Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. <del>The Department is proposing language to delay an additional checkwrite for FY 2012-13. From then on, two checkwrites would be delayed at the end of each fiscal year.</del> <b><u>Beginning in FY 2012-13, an additional checkwrite will be delayed at the end of each fiscal year.</u></b></p> <p><del>The checkwrite normally paid on June 20, 2013 would be paid in July 2013. This delay will result in a decrease in expenditures estimated to be \$355.2 million TF in FY 2012-13.</del></p> <p><del>In addition to delaying a checkwrite, the Department is also proposing to delay delaying one month of managed care capitation rates <b><u>beginning</u></b> in FY 2012-13. This delay will result in a decrease in expenditures estimated to be \$1,230.0 million TF in FY 2012-13.</del></p>
R 31	(PC-173) X	X	<p><u>Part D—Phased-Down Contribution</u></p> <p>With the implementation of Medicare Part D, the federal government requires a phased down contribution from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the phased-down contribution was 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. An annual inflation factor is also applied to the phased-down contribution. The phased-down contribution, annual CMS-determined inflation factor, and PMPM are adjusted annually.</p>
R 32	(OA-71) X	X	<p><u>CDPH I&amp;E Program and Evaluation</u></p> <p>AB 1762 (Chapter 301, Statutes of 2003) authorized the Department to require contractors and grantees under the Information and Education (I&amp;E) program to establish and implement clinical linkages to the Family PACT program, effective FY 2003-04. This linkage includes planning and development of a referral process for program participants, to ensure access to family planning and other reproductive health care services.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

				The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.
R 33	(PC-NA)	X	X	<u>Operational Flexibilities</u>
				This assumption has been moved to the "Withdrawn" section.
R 34	(PC-41)	X	X	<u>Youth Regional Treatment Centers</u>
				The Department will implement the enrollment and reimbursement of the Youth Regional Treatment Centers (YRTCs) under the Indian Health Service program. YRTCs provide American Indian youths culturally appropriate inpatient substance abuse treatment. The Department will receive Title XIX reimbursement for services provided to eligible American Indian Medi-Cal beneficiaries under the age of 21.
R 35	(PC-NA)	X		<u>Cost Shift of CCS State-Only to Medi-Cal EPC</u>
				This assumption has been moved to the "Time Limited/No Longer Available" section.

**OTHER RECOVERIES: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

RC 0.1(PC-199)

X

Recovery of PCS/IHSS

SB 412 (Chapter 548, Statutes of 1995) permits the Department to seek estate recovery (ER) against the estate of the decedent, or any recipient of the property of the decedent, for health care services received. The Department proposed regulations to include Personal Care Services (PCS), a service offered under the In-Home Supportive Services (IHSS) program, in ER claims. The addition of PCS is expected to increase savings for the Department.

**OTHER RECOVERIES: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
RC 1 (PC-202)	X	X	<p><u>Base Recoveries</u></p> <p>Medi-Cal recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances. Recoveries are based on trends in actual collections.</p>
RC 2 (OA-22)	X	X	<p><u>Medi-Cal Recovery Contracts</u></p> <p>The Department contracts with vendors to identify third party health insurance and workers compensation insurance. When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries.</p>
RC 3 (PC-193)	X	X	<p><u>Anti-Fraud Activities for Pharmacy and Physicians</u></p> <p><del>In FY 2011-12, the</del> <b>The</b> Department expanded its anti-fraud activities. <del>The activities focus on pharmacy and physician services.</del></p>
RC 4 (PC-200) (OA-46)	X	X	<p><u>Medicare Buy-In Quality Review Project</u></p> <p>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 buy-in process for Medicare/Medi-Cal dual eligibles. UMASS assists the Department by auditing the invoices received from CMS to pay the Medicare premiums. The Department realized savings beginning in October 2012. Payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers. The Department extended the contract through June 30, 2015.</p>

**FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 0.1 (PC-FI)	X	X	<p><u>Fiscal Intermediary Change Orders</u></p> <p>A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the Fiscal Intermediary (FI).</p>
FI 0.2 (PC-FI)	X	X	<p><u>Provider Applications and Validation for Enrollment</u></p> <p>To comply with Medicaid Information Technology Architecture (MITA) and the Affordable Care Act (ACA) federal mandates, the Department has requested the FI to make system modifications to enhance the capabilities of the CA-MMIS Health Enterprise Provider Enrollment functionality. The Department will reimburse the FI for increased costs related to the system changes including any required licensing, maintenance and support.</p>
FI 0.3 (PC-FI)	X	X	<p><u>Telephone Service Center – Customer Service Improvement Project</u></p> <p>The Department anticipates a high volume of calls received by the Telephone Service Center (TSC) as a result of the ACA, Medi-Cal expansion, and newly eligible individuals represented under Covered California. The increased call volume will move the total expected calls above the maximum band for the bid rate per call in the FI contract. Exceeding the maximum band will increase the rate per call, resulting in an increase in the total cost for the TSC. The Department is in negotiation with the FI to amend the contract and expand the maximum band and set a new bid rate per call.</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-NA)	X	X	<p><u>Cost Containment Proposals – Savings Sharing</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
FI 2	(PC-NA)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
FI 3	(PC-FI)	X	X	<p><u>HIPAA – CA-MMIS</u></p> <p>HIPAA requires uniform national health data standards, unique identifiers and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff is required to provide for remediation/implementation of HIPAA changes to the CA-MMIS and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, and high level work on other rules. APDs will continue to be submitted as new rules are published to continue to secure enhanced funding.</p> <p>The necessary work is associated with the following HIPAA regulations:</p> <ul style="list-style-type: none"> <li>• Privacy (Completed)</li> <li>• Transactions and Codes (Completed)</li> <li>• Unique Employer Identifier (Completed)</li> <li>• Security (In Progress)</li> <li>• National Provider Identifier (Completed)</li> <li>• Electronic Signature (Future Project)</li> <li>• Enforcement (Completed)</li> <li>• National Health Plan Identifier (Future Project)</li> <li>• Claims Attachments (Future Project)</li> <li>• First Report of Injury (Future Project)</li> <li>• Transactions and Code Sets Revisions (In Progress)</li> </ul>

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased-in approach to implement the most critical (in terms of

## FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation began in October 2003 and the remaining transactions and code conversions will continue to be phased-in and implemented. The January 16, 2009 published HIPAA rules will require MMIS changes in order to incorporate updated transactions for Medi-Cal and prescription drug claims by the federal compliance date of January 1, 2012. The final rules also require the implementation of a new diagnosis and inpatient hospital procedure coding standard, ICD-10, by October 1, 2013. CMS recently extended the October 1, 2013 deadline to October 1, 2014 for ICD-10.

FI 4 (PC-NA) X

### Extension of the HP Contract

This assumption has been moved to the "Time Limited/No Longer Available" section.

FI 5 (OA-35) X X

### Medicaid Information Technology Architecture

The CMS is requiring the Department to create frameworks and technical specifications for the MMIS of the future. CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through Medicaid Information Technology Architecture (MITA) the Department will develop the ability to streamline the process to access information from various systems. CMS will not approve APDs or provide federal funding to the Department without adherence to MITA.

The Department completed the CMS-required MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements **in 2008 utilizing the then-current MITA Framework Version 2.0. MITA Framework Version 3.0 was released in March 2012. A new SS-A effort using the MITA 3.0 version is currently underway.** The Department must complete an annual SS-A that **which will** contain a roadmap that demonstrates progression along the MITA model. The Department is currently developing Enterprise Architecture (EA) at the Agency level to address MITA EA activities. **Information Architecture standards and activities are currently underway.**

**In June 2013, an advance planning document update (APDU) and draft Request for Offer (RFO) were submitted to CMS.**

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				<b><u>The plan outlines the effort necessary to perform the annual SS-A submission and updates the initial roadmap.</u></b>
FI 6	(OA-19)	X	X	<p><b><u>CA-MMIS Takeover System and Replacement Oversight</u></b></p> <p>CA-MMIS is the claims processing system used for Medi-Cal. This system has changed considerably over the past 30 years to incorporate technological advances as well as to address new business and legislative requirements and, as a result, is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. CA-MMIS is a mission critical system that must assure timely and accurate claims processing for Medi-Cal providers. Given the business critical nature of CA-MMIS, a detailed assessment was completed by a specialty vendor which recommends that modernization of CA-MMIS begin immediately. The Department contracts with various vendors to assist with FI oversight activities, documentation of business rules, <b><u>technical architecture, federal certification management</u></b>, project management, <b><u>change transition</u></b> management and <b><u>IV&amp;V independent validation &amp; verification</u></b> services during transition and replacement of the CA-MMIS <b><u>system</u></b>.</p>
FI 7	(PC-NA)	X		<p><b><u>CA-MMIS Takeover by New FI Contractor</u></b></p> <p>This assumption has been moved to the "Time Limited/No Longer Available" section.</p>
FI 8	(OA-18)	X	X	<p><b><u>CA-MMIS Takeover/ System Replacement Other State Transition Costs</u></b></p> <p>CA-MMIS is the claims processing system used for Medi-Cal. <del>The previous FI contract will expire on June 30, 2013.</del> Additional <b><u>The transition</u></b> costs <del>will be</del> incurred for CA-MMIS Takeover and Replacement activities <del>which</del> include interfacing with other Departmental mission critical systems such as MEDS, EMBER, SCO, MIS/DSS, <b><u>CalHEERS</u></b> and PCES applications that <del>will</del> require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system, <b><u>user acceptance</u></b> and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

new environments in support of transition activities during the ~~Takeover and Replacement phases.~~ **phase.** The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during ~~both phases~~ **the Replacement phase.** ~~The Takeover activities are expected to be completed in FY 2012-13, and~~ Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS Replacement phase.

FI 9 (PC-FI) X X

CA-MMIS System Replacement Project

The Department plans to replace the 30-year old CA-MMIS. CA-MMIS is a mission critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The Department continues to update the current system to incorporate technological advances. The updates address new business and legislative requirements. Because of the updates, CA-MMIS is extremely complex, difficult to maintain, and near the end of its useful life cycle. A specialty vendor completed a detailed assessment of the current system. Due to the business critical nature, the vendor recommended that the modernization of CA-MMIS begin immediately. The Department scheduled the CA-MMIS System Replacement Project in four phases.

Business Rules Extraction (BRE) will occur at the beginning of each phase. The objective of the BRE Enhancement is to define a comprehensive rules base for the Legacy CA-MMIS and to store the confirmed rules in a requirements traceability database. The traceability database is for tracking future testing, management, and updates. Business rules link to requirements, which are the key building blocks of a system development project. ~~The Department expects BRE related costs to begin~~ **began** in FY 2012-13.

In Phase I, Pharmacy Benefits Manager and Drug Rebate, the Department plans to implement a new pharmacy claims system. This includes three major components:

- Real-time Point-of-Service (POS) and batch claims processing,
- The rebate collection and tracking system, and
- The drug utilization review (both prospective and retrospective).

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Planning work on the system began in January 2012. The Department plans to implement Phase I in February 2015.

In Phase II, TARS-RX Authorizations, the Department plans to:

- Replace the existing Treatment Authorization Request (TAR) System for pharmacy services only,
- Establish ~~two~~ **a** TAR Processing ~~Centers~~ **Center**, and
- Consolidate existing Field Office Automation Group (FOAG) activities.

~~The Department scheduled Phase II to begin~~ **planning began** in February 2013, **with an expected implementation date of July 2015**. Based on the existing pay schedule, actual costs will be incurred in FY ~~2013-14~~ **2014-15**.

In Phase III, TARS-Medical Authorizations, the Department plans to implement a new Medical Authorizations system. This involves replacing:

- The remainder of the SURGE system,
- The Medical Treatment Authorization Requests (MeTARS), and
- The TAR Appeals Process.

The Department scheduled Phase III to begin in FY 2013-14.

In Phase IV, CMSNeT, TPL, ACMS, CalPOS, and RTIP Full Replacement, the Department plans to replace:

- The Children's Medical Services Network (CMSNeT),
- Third Party Liability (TPL) system,
- Automated Collection Management System (ACMS),
- The remaining pieces of the California Point of Service (CalPOS) system, and
- The Real Time Internet Pharmacy (RTIP) system.

The Department scheduled the final phase **of planning** to begin in FY ~~2013-14~~ **2014-15**.

FI 10 (PC-FI)    X    X

CA-MMIS Re-Procurement-HIPAA ICD-10 Legacy Enhancement

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government issued a Final Rule on

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. Medi-Cal currently uses ICD-9 coding, as does the majority of the national health care industry, as critical data for claims processing, prior authorization, fraud investigation, and other program operations. The Final Rule for ICD-10 indicates an expectation that efforts to begin addressing these requirements begin no later than January 2011. In August 2012, Centers for Medicare and Medicaid Services (CMS) changed the compliance date from October 1, 2013 to October 2, 2014.

The new contract for the CA-MMIS was awarded to Xerox, and includes an enhancement of the existing system to address ICD-10 requirements, and the acquisition and utilization of software tool for code management. Planning, analysis, development and implementation of the CA-MMIS ICD-10 enhancement is in process.

FI 11 (PC-FI)    X    X

CA-MMIS Re-Procurement – 5010/D.0 Legacy Enhancement

As part of the HIPAA, the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt new versions of the standards for electronically exchanging critical administrative health care transactions, including health care claims, eligibility information, prior authorizations, and payment information. These changes will impact the vast majority of Medi-Cal providers and managed care plans. These new versions are maintained by two national standards organizations; X12 and the National Council for Prescription Drug Programs (NCPDP). The X12's transactions are part of the standard called "5010," while NCPDP's standard is called "D.0". The federal compliance deadline is was January 1, 2012; however, the activities continued until December 31, 2012.

The new contract for the CA-MMIS was awarded to Xerox, and includes an enhancement of the existing system to address the 5010/D.0 transaction requirements. The planning, analysis, and development of the CA-MMIS 5010/D.0 was completed, with implementation into CA-MMIS occurring on July 1, 2012. The Department will allow Medi-Cal providers to continue to submit claims in the old format for a limited period of time and will

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				continue to make additional modifications that are anticipated to result in additional costs carrying over into FY 2013-14.
FI 12 (PC-FI)	X	X	<u>Rebate Accounting and Information System Hardware and Software Refresh</u>	<p>The Rebate Accounting and Information System (RAIS) supports invoicing of pharmaceutical drugs, physician-administered drugs, and medical supply rebates.</p> <p>RAIS is built upon technology that is client server oriented. Since the hardware technology is constantly changing and expanding, the hardware has a limited life span. In order to avoid memory storage reaching maximum capacity and hardware components failing due to the age of the equipment, the FI Contractor is required to evaluate RAIS hardware and software every five years. The last refresh of the RAIS platforms was completed in 2005. The FI Contractor's review of RAIS determined that the RAIS hardware has reached its end of life. The refresh is expected to begin in FY <del>2012-13</del> <b>2013-14</b>.</p>
FI 13 (PC-FI)	X	X	<u>Point of Service Refresh</u>	<p>Medi-Cal providers are currently able to use the Point of Service (POS) devices to verify Medi-Cal recipients' eligibility, and perform claims-related transactions including: decrement Share of Cost (SOC), submit pharmacy transactions for immediate on-line adjudication, access the Child Health and Disability Prevention Gateway, and submit Family Planning, Access, Care and Treatment transactions.</p> <p>The devices that support the POS network are out-of-date and need to be replaced to comply with the new HIPAA transactions standards. Implementation of the POS refresh is scheduled to be completed in March 2014.</p>
FI 14 (OA-47)	X	X	<u>MIS/DSS Contract Reprocurement Services</u>	<p>The contract for ongoing development, maintenance, and operation of the Management Information System and Decision Support System (MIS/DSS) is scheduled to end on February 14, 2014. The Department <del>will contract</del> <b>contracted</b> with a vendor to provide assistance with the reassessment of the scope of services to be included in the reprocurement of the MIS/DSS contract beginning in FY 2012-13. Resources are needed to develop the</p>

## FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

				Feasibility Study Report and APD to achieve required state and federal level approvals.
FI 15 (PC-FI)	X	X	<u>Clarity Software</u>	<p>The federal health reform initiatives require the Department to effectively and efficiently initiate, manage, monitor and report human and cost resources.</p> <p>Clarity is a portfolio management tool designed for prioritization, efficiency, and analysis. This tool <del>will help</del> <b>helps</b> the Department manage the various <b>business and</b> technology undertakings that are required to make improvements to the Medi-Cal fiscal intermediary process and for implementing the new California Medicaid Management Information System (CA-MMIS), which will bring additional efficiencies and functionality to support the Medi-Cal program.</p>
FI 16 (PC-FI)	X		<u>Additional CA-MMIS Office Space</u>	<p>The Department has <del>decided to locate</del> <b>consolidated</b> all CA-MMIS staff in one location and has directed Xerox to provide additional office space within the new Medi-Cal Operations Center (MOC) facility in West Sacramento, CA. This office space exceeds the FI's contractual office space requirements. The build out of additional office space is <b>was</b> <del>expected to be completed by</del> <b>in</b> FY 2012-13. <b><u>Final payment is anticipated to be made in FY 2013-14.</u></b></p>
FI 17 (OA-31)	X	X	<u>SDMC System M&amp;O Support</u>	<p>The Department has started procuring a contract for ongoing operation and maintenance of the Short-Doyle/Medi-Cal (SDMC) system. The SDMC system adjudicates Medi-Cal claims for specialty mental health and substance use disorder services. <b><u>The current contract ends on June 30, 2014.</u></b> <del>This contract will be for a two year period beginning June 29, 2013, with three one-year optional extensions.</del> <b><u>The Department plans to enter in a two-year contract beginning July 1, 2014, with two one-year optional extensions.</u></b></p>
FI 18 (OA-50)	X	X	<u>Annual EDP Audit Contractor</u>	<p>The Department plans to procure an independent Certified Public Accounting firm to provide a contractually required annual</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Electronic Data Processing (EDP) audit of the Medi-Cal fiscal intermediary. The Department will use the findings and recommendations of the audit as part of its ongoing CA-MMIS monitoring process.

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

HO 0.1 (PC-FI) X X Fiscal Intermediary Change Orders

A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the FI.

HO 0.2 (PC-FI) X Beneficiary Dental Exception

AB 1467 (Chapter 23, Statutes of 2012) was enacted July 1, 2012, to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental managed care plans in Sacramento County. The intent of the legislation is to improve access to dental care by implementation of the Beneficiary Dental Exception (BDE) process. The BDE is available to beneficiaries in Sacramento County who are unable to secure services through their dental plan, in accordance with applicable contractual timeframes and the Knox-Keene Health Service Plan Act of 1975. The BDE allows a beneficiary to opt-out of Medi-Cal Dental Managed Care and move into fee-for-service (Denti-Cal).

The BDE notifications will be mailed to beneficiaries in Sacramento County. New enrollees will receive a BDE notification after they have been enrolled in a dental plan for 90 days based on the initial effective date of the enrollment transaction. The effective date for the first mailing for the 90 day BDE notification is August 1, 2013. Thereafter, currently enrolled beneficiaries will receive a BDE notification on an annual basis. The first mailing for the annual notification is September 1, 2013. The Department will incur additional costs for these mailings.

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 1 (PC-FI)	X	X	<p><u>Personalized Provider Directories</u></p> <p>Health Care Options (HCO) currently prints and mails health plan Provider Directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. AB 203 (Chapter 188, Statutes of 2007) authorized the implementation of a Personalized Provider Directory (PPD) as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the Personalized Provider Directories were determined in consultation with health plans and stakeholders. The pilot project began on February 27, 2009. At the end of the pilot project period, the Department, in consultation with health plans and stakeholders, performed an assessment to determine if Personalized Provider Directories provide more accurate, up-to-date provider information to Medi-Cal managed care beneficiaries, in a smaller, standardized, and user-friendly format that results in a reduction of default assignments, and if they should be implemented statewide in all managed care counties. Based upon the assessment, the Department decided to continue the pilot.</p>
HO 2 (PC-NA)	X	X	<p><u>Health Care Options Consultant Costs</u></p> <p>This assumption has been moved to the "Withdrawn" section.</p>
HO 3 (PC-FI)	X	X	<p><u>Updates to Existing HCO Informing Materials</u></p> <p>Existing HCO informing materials will be reviewed and revised to reflect changes associated with the current health care environment. These include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Current managed care requirements,</li> <li>• New program needs and modifications, <ul style="list-style-type: none"> <li>○ Shifts from voluntary to mandatory eligibility requirements</li> <li>○ Changes in plan or provider eligibility</li> </ul> </li> <li>• Compliance with Federal Health Care Reform law.</li> </ul> <p>All informing materials used by the Department in the Medi-Cal Managed Care HCO program will be updated. The updates will generate costs for production, printing, and threshold language translations.</p>

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

HO 4 (PC-BA) X

Health Plan of San Joaquin Replacing Anthem Blue Cross as LI in Stanislaus County

This assumption has been moved to the “Fully Incorporated in the Base Data/Ongoing” section.

**FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

DD 0.1 (PC-FI)	X	X	<p><u>Fiscal Intermediary Change Orders</u></p> <p>A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the FI.</p>
DD 0.2 (OA-54)	X	X	<p><u>Department of Managed Health Care Inter-Agency Agreement</u></p> <p>SB 853 (Chapter 717, Statutes of 2010) authorized the Department to enter into an interagency agreement with the Department of Managed Health Care (DMHC) to ensure compliance with the Medi-Cal contract by conducting financial audits, dental surveys, and a review of the provider networks of the managed care plans participating in Medi-Cal. The projected implementation of the inter-agency agreement with the DMHC is September 2013.</p>
DD 0.3 (OA-33)	X	X	<p><u>Business Rules Extraction (BRE) Software and Services</u></p> <p>The Department plans to procure a new dental MMIS contract that meets CMS's requirements.</p> <p>In order to provide an equal advantage to all participating bidders, the Department plans to purchase a Business Rules Extraction suite of tools and services for use in the creation and maintenance of a modernized automated comprehensive procurement library. Bidders will gain a better understanding of the functionality and complexity of the legacy system CD-MMIS enabling them to complete an informed more competitive bid.</p> <p>This modernized procurement library will provide the following:</p> <ul style="list-style-type: none"> <li>• Full disclosure of graphic and logical views of the applications/programs.</li> <li>• Update business rules periodically, allowing viewing of the latest versions of process diagrams, source code flow charts, and source code details.</li> <li>• Ability to electronically store documentation.</li> </ul>

**FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- Utilize extracted business rules to support future system enhancements, replacement, or the migration to one enterprise-wide system.

**FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 1 (PC-FI)	X	X	<u>HIPAA – CD-MMIS</u>

HIPAA requires uniform national health data standards, unique identifiers, and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the California Dental Medicaid Management Information System (CD-MMIS) and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) were submitted to CMS and were approved for enhanced funding for Transactions. APDs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Electronic Signature (Completed)
- Enforcement (Completed)
- Adoption of Rules for a Unique Health Plan Identifier (HPID) (In Progress)
- Claims Attachments (Pending)
- First Report of Injury (Completed)
- Transaction Revisions (Completed)
- Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claims Status Transactions (In Progress)
- Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance (In Progress)
- **Adoption of Operation Rules for Connectivity (In Progress)**

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased in approach to implement the most critical transactions (in terms of provider impact) and code sets first, without interrupting payments to providers or services to beneficiaries. The July 8, 2011 published HIPAA rules require changes to the Claim Status Transactions and Companion Guides and had a compliance date of January 1, 2013. The September 5, 2012 published HIPAA rules adopted the standard for a national unique health plan identifier (HPID) and requires changes to CD-MMIS in order to meet the federal compliance date of November 7, 2016.

**FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
DD 2 (PC-FI)	X	X	<p><u>Medi-Cal Dental FI Contract Turnover</u></p> <p>CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department <del>is seeking</del> <b>received</b> approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension <del>begins</del> <b>began</b> July 1, 2013 <b>and goes</b> through June 30, 2015. The Department plans to develop a Planning Advanced Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements.</p> <p>The Department has instructed the FI contractor to resume turnover support services and all activities in accordance with the contract requirements. The Turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in addition to supporting the Department's procurement effort by ensuring that all required data and documentation was included in the Office of Medi-Cal Procurement's data library.</p>
DD 3 (PC-FI)	X	X	<p><u>CD-MMIS Takeover by New Dental FI Contractor</u></p> <p>The dental FI operates CD-MMIS, which is the Medi-Cal dental claims processing system. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. The Department issued a RFP to establish a new FI contract. In August 2011, the Department evaluated the bids and published the Notice of Intent to Award.</p> <p>In February 2012, the new dental FI began takeover activities. However, CMS determined the new Medi-Cal Dental FI contract failed to meet the regulatory criteria and conditions as a MMIS. Subsequently, the Department exercised the one-time extended operations option of the current Dental FI contract for the period of June 1, 2012 through June 30, 2013. <b><u>Additionally, the Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract, extending operations of the current Dental FI contract for the period of July 1, 2013 through June 30, 2015.</u></b> The Department instructed the FI contractor to stop all Takeover activities. The FI contractor filed a Notification of Claim to recoup costs already expended for Takeover activities. <b><u>The Department has determined that the FI contractor should be reimbursed and is currently working with CMS to determine if FFP will be available for these costs.</u></b></p>

## FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

**Takeover Activities for the new FI contractor are expected to begin October 1, 2014.**

DD 4 (PC-FI)	X	X	<p><b><u>Extension of the Current Medi-Cal Dental FI Contract</u></b></p> <p>CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department <del>is seeking</del> <b>received</b> approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The Department plans to develop a Planning Advanced Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements.</p>
DD 5 (OA-48)	X	X	<p><b><u>Dental PAPD Project Manager</u></b></p> <p>The Department completed the procurement for the CD-MMIS Fiscal Intermediary and published the Notice of Intent in August 2011. CMS determined the new dental contract no longer meets the regulatory criteria and conditions as a MMIS acquisition. Therefore, the contract is not eligible for enhanced FFP at 75%.</p> <p>The <b><u>Effective June 10, 2013, the</u></b> Department <del>plans to procure</del> <b>procured</b> a Certified Project Manager (CPM) to develop and obtain CMS approval of a PAPD. The Project Manager's responsibilities include:</p> <ul style="list-style-type: none"> <li>• Provide project management expertise,</li> <li>• Provide status reporting, and</li> <li>• Advise the Department to ensure CMS approval of the dental FI contract as an MMIS at the enhanced level.</li> </ul>

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**INFORMATION ONLY**
**REVENUES**1. Revenues

The State is expected to receive the following revenues from quality assurance fees (accrual basis):

FY 2012-13: \$ 23,170,000	ICF-DD Quality Assurance Fee
\$ <del>510,264,000</del> <b><u>510,265,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 6,620,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ <del>4,090,000</del> <b><u>1,218,000</u></b>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ <del>204,694,000</del> <b><u>383,441,000</u></b>	Gross Premium Tax (AB 1422)
\$2,915,076,000	Hospital Quality Assurance Revenue Fund (4260-610-3158)
\$ <del>42,806,000</del> <b><u>10,246,000</u></b>	Emergency Medical Air Transportation Fund (EMATA)
\$3,673,720,000 <b><u>3,850,036,000</u></b>	Total
FY 2013-14: \$ 23,153,000 <b><u>25,511,000</u></b>	ICF-DD Quality Assurance Fee
\$ <del>494,096,000</del> <b><u>504,407,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 6,620,000 <b><u>7,653,000</u></b>	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ <del>1,257,000</del> <b><u>1,204,000</u></b>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ <del>884,454,000</del> <b><u>783,818,000</u></b>	MCO Tax
\$3,181,559,000 <b><u>3,364,557,000</u></b>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$ <del>42,806,000</del> <b><u>10,246,000</u></b>	Emergency Medical Air Transportation Fund (EMATA)
\$4,603,945,000 <b><u>4,697,396,000</u></b>	Total
FY 2014-15: \$ 25,515,000	ICF-DD Quality Assurance Fee
\$ 509,837,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 7,653,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ 1,218,000	Freestanding Pediatric Subacute Quality Assurance Fee
\$ 1,252,660,000	MCO Tax
\$ 4,103,128,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)

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\$ 10,246,000	Emergency Medical Air Transportation (EMATA) Fund
\$ 5,910,257,000	Total

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee is assessed, to include Medicare for AB 1629 facilities.

The FY 2011-12 ICF/DD Transportation/Day Care QA fee includes a one-time retroactive collection of \$22.5 million in QA fees for FY 2007-08 through FY 2010-11. In addition to the retroactive QA fees, the QA fee includes an estimated \$6.1 million for FY 2011-12. The ICF/DD Transportation/Day Care QA fee is expected to remain consistent in future years.

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS approval.

AB 1422 (Chapter 157, Statutes of 2009) has imposed an additional tax on the total operating revenue of all Medi-Cal managed care plans. The provision pertaining to this tax will be effective retroactive to January 1, 2009 until June 30, 2012. The Department is proposing legislation that will eliminate the gross premium tax sunset date on the total operating revenue of Medi-Cal managed care plans. The permanent extension of the tax will generate additional General Fund revenue.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund will be used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund will also be used to pay for health care coverage for children, staff and related administrative expenses required to implement the QAF program. SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to enactment of a new hospital QAF that results in FY 2011-12 revenue for children's services of at least \$320 million.

SB 335 (Chapter 286, Statutes of 2011) authorizes the implementation of a new Hospital Quality Assurance Fee (QAF) program for the period of July 1, 2011 to December 31, 2013. This new program will authorize the collection of a quality assurance fee from non-exempt hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue and will be used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee

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amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which will result in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations.

### 2. Redevelopment Agency and Local Government Funds

The amended 2009 Budget Act included a \$3.6 billion expenditure transfer of Redevelopment Agency and local government funds to the General Fund to offset General Fund expenditures. Of the \$3.6 billion transfer, \$572,638,000 has been attributed to the Medi-Cal program for accounting purposes. The transfer provides funds directly to the General Fund, and cash does not flow through the Department of Health Care Services. The transfer does not affect Medi-Cal payments or the estimate.

## ELIGIBILITY

### 3. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The current sunset date has been extended to December 31, 2013 by HR 3630, the Middle Class Tax Relief and Job Creation Act of 2012.

### 4. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. The current sunset date has been extended February 29, 2012 by HR 3765, the Temporary Payroll Tax Cut Continuation Act of 2011.

### 5. Impact of SB 708 on Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care

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services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected in FY 2012-13 and FY 2013-14 due to the spending limit.

### 6. Ledezma v. Shewry Lawsuit

The Department negotiated a settlement of *the Ledezma v. Shewry* lawsuit. The suit resulted from a system programming error that discontinued Qualified Medicare Beneficiaries (QMB) at annual re-determination. Eligibility for Medicare Part A has been restored and affected beneficiaries have been reimbursed for the cost of their premiums. The Department remains responsible for the cost of reimbursing out-of-pocket medical expenses for qualified claims. Settlement costs are not significant. The parties determined the scope of the Department's liability by contacting beneficiaries who may have incurred out-of-pocket expenses. Beneficiary reimbursements and costs associated with the beneficiary reimbursement process are not eligible for federal matching funds.

### 7. Electronic Asset Verification Program

Due to the requirements imposed by H.R. 2642 of 2008, the Department is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD) applicants/beneficiaries through electronic requests to financial institutions. The Department will enter into a contract with a financial vendor that will enable the counties to receive asset information for the ABD population. The financial vendor will provide counties with data from financial institutions that could indicate assets and property not reported by the applicant or beneficiary. The counties will have the responsibility to require the applicant or beneficiary to provide additional supporting documentation before an eligibility determination is made. There will be undetermined costs for a third party contract as well as reimbursements to financial institutions. Although savings from asset and eligibility verification are currently indeterminate, savings/cost avoidance will be achieved when supplemental data increases the accuracy of eligibility determinations for the ABD population. The implementation date of this program is currently unknown.

### 8. Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families, and the regional centers to transition residents to community living arrangements. If eligible for Medi-Cal, residents moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system. It is not known when the transitions will begin.

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**INFORMATION ONLY****AFFORDABLE CARE ACT****9. Realignment**

**Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public /non-County Medical Services Program counties will have the option to select one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for Medi-Cal and the uninsured, option 2 is redirection of 60% of a county's health realignment allocation plus maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) lays out the methodology for the formula in option 1, and requires the department to perform the calculation. AB 85 also lays out new county enrollment requirements, including enrollment targets, and requires the Department to administer these new requirements.**

**The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be \$300 million in FY 2013-14, and \$900 million in FY 2014-15.**

**BENEFITS****10. State-Only Anti-Rejection Medicine Benefit Extension**

Assembly Bill 2352 (Chapter 676, Statutes of 2010) requires Medi-Cal beneficiaries to remain eligible for State-Only Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant unless, during that time, the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. Currently, some patients qualify for Medi-Cal under a federal rule allowing coverage for anti-rejection medication for one year post organ transplant. After this eligibility ends, the Department will no longer receive FFP. Therefore, the costs for extending this benefit will be 100% General Fund. The fiscal impact is indeterminate.

**11. CDSS IHSS Share-of-Cost Buyout**

The CDSS and the Department implemented a process that enabled Medi-Cal IHSS recipients who had a Medi-Cal SOC higher than their IHSS SOC to pay the IHSS SOC. Without the payment from CDSS each IHSS recipient with a Medi-Cal SOC that exceeded his/her IHSS SOC was required to meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

An Interagency Agreement between CDSS and CDHS established the process for the transfer of CDSS funds to prepay the Medi-Cal SOC for IHSS recipients.

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Effective October 2009, the SOC Buy-Out provision ended, however the reconciliation process of outstanding claims will continue up to the allowable claiming period.

### HOME & COMMUNITY BASED-SERVICES

#### 12. AB 398—Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project. **Instead, the Department is exploring ways to serve this population through the Assisted Living Waiver.**

#### 13. Assisted Living Waiver Expansion

AB 499 (Chapter 557, Statutes of 2000) required the Department to develop a waiver program to test the efficacy of providing assisted living as a Medi-Cal benefit for elderly and disabled persons in Residential Care Facilities for the Elderly (RCFEs), and Publicly Subsidized Housing (PSH). In June 2005, CMS approved the Assisted Living Waiver (ALW) Pilot Project and in March 2009 approved the renewal of the waiver for a five-year period. This increased the waiver capacity beginning in FY 2011-12. Vacant slots are continually backfilled. **The Department is currently working with CMS to expand provision of ALW services into additional counties, and to serve eligible beneficiaries living with brain injuries.**

### BREAST AND CERVICAL CANCER TREATMENT

### PHARMACY

#### 14. Average Acquisitions Cost as the New Drug Reimbursement Benchmark

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. First Databank, the Department's primary drug price reference source ceased publishing AWP as of September 2011. AB 102 (Chapter 29, Statutes of 2011) gave the Department the authority to establish and implement a new methodology for Medi-Cal drug reimbursement that is based on average acquisition cost (AAC). If CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the new statute. To ensure the benchmark is in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.

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**INFORMATION ONLY****15. Federal Upper Limit**

The Deficit Reduction Act (DRA) of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175% of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated. These changes will result in an indeterminate change in the amount the Department reimburses for generic drugs. On May 23, 2011, CMS reported that a notice of proposed rulemaking (NPRM) implementing the changes to AMP had been drafted and was under review. The Department plans to implement the FULs, after federal regulations have been published and/or final FULs are provided by CMS.

**DRUG MEDI-CAL****16. Naltrexone Treatment Services**

Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and substance use disorder diagnoses. Naltrexone blocks the euphoric effects of opioids and helps prevent relapse to opioid use. Naltrexone services are not provided to pregnant women. While these benefits are available, beneficiaries are currently not utilizing the service.

**1115 WAIVER—MH/UCD & BTR****MANAGED CARE****PROVIDER RATES****SUPPLEMENTAL PAYMENTS****17. Designated Public Hospitals – Seismic Safety Requirements**

AB 303 (Chapter 428, Statutes of 2009) authorizes Medi-Cal supplemental reimbursement to Designated Public Hospitals for debt service incurred for the financing of eligible capital construction projects to meet seismic safety requirements.

Eligible projects will be limited to meeting seismic safety deadlines, and will include those new capital projects funded by new debt for which final plans have been submitted to the Office of Statewide Health Planning and Development after January 1, 2007, and prior to December 31, 2011.

There will be no expenditures from the State General Fund for the nonfederal share of the supplemental reimbursement. The nonfederal share will be comprised of either certified public expenditures or intergovernmental transfers.

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The Department is assessing federal approval requirements for implementation of this supplemental payment program. Implementation will occur only if federal approvals are obtained and federal financial participation is available.

**18. Hospital Inpatient Rate Freeze**

The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.

**OTHER: AUDITS AND LAWSUITS****19. Mission Hospital Regional Medical Center and Kaiser Foundation Hospitals et al. v. Douglas**

Plaintiffs are approximately 100 California hospitals that filed litigation in 2005 to challenge the validity of a limit on Medi-Cal reimbursement for FY 2004-05 for non-contract hospitals, which was enacted by SB 1103 (Chapter 228, Statutes of 2004). Plaintiffs contend the SB 1103 reimbursement limit violates the federally approved State Plan and various federal Medicaid laws, including 42 United States Code (U.S.C.) section 1396a(a)(30)(A), as well as the due process clause and contracts clause of both the United States and California constitutions.

The trial court issued an order June 19, 2009 that required the Department to recalculate the rates for the plaintiff hospitals for FY 2004-05 without applying the SB 1103 limit and pay them the additional money they would be owed. The Department appealed, and the Court of Appeal reversed the trial court's order. At a hearing on April 27, 2012, the trial court denied the plaintiffs' motion to amend their lawsuit to state a claim for money based on the state recalculating their rates for FY 2004-05 without applying the SB 1103 limit. A judgment is expected soon that will deny the plaintiffs the recalculated rates they seek. **On April 30, 2013, the trial court issued a final judgment that specified the Department was not required to recalculate rates that were originally determined based on the SB 1103 limit.** However, the **80 of the hospitals that were** plaintiffs **in the 2005 lawsuit**, filed a new lawsuit in November 2011 in which they again challenge the validity of the SB 1103 reimbursement limit and the new lawsuit specifically seeks a court order to require the Department to recalculate rates for FY 2004-05 without applying the SB 1103 reimbursement limit. **A judgment is expected in the new lawsuit later in FY 2013-14.**

**20. California Association for Health Services At Home, et al., v. Sandra Shewry**

Plaintiffs (an association of home health care providers, a home health care provider, and a disability rights advocacy group) filed a lawsuit on April 27, 2004 seeking reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement; the Medicaid Act's "access" and efficiency, economy, and quality of care ("EEQ") provisions; federal regulation (42 C.F.R. § 447.204) and the State Plan.

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In March 2007, following an appeal of a trial court decision, the Court of Appeal issued a published decision holding that:

- The Department was required to review reimbursement rates for home health services annually for years 2001 through 2005 to ensure that they comply with the former State Plan provision incorporating 42 U.S.C. 1396a(a)(30)(A), and
- The Department was not obligated to set new rates – i.e., for years after 2005.

Following the appellate decision, the Department completed a rate review and concluded that rates paid to home health care providers for 2001-2005 were consistent with section 1396a(a)(30)(A). After the rate review was filed with the trial court, plaintiffs objected. On September 25, 2009, the trial court held that the Department did not perform a proper rate review in light of the standard set forth in *Orthopaedic Hospital v. Belshe*. The court ordered the Department to perform a further rate review.

The Department appealed the trial court's ruling. On March 26, 2012, the appellate court issued a published decision, affirming in part and reversing in part, holding:

- The Department was not required to consider provider costs under section 30(A) when performing the rate review,
- Section 30(A)'s requirement of "efficiency" and "economy" did not impose a minimum limit for, Medi-Cal reimbursement rates,
- Lack of complaints was sufficient to establish quality of care under section 30(A), and
- There was insufficient evidence to support the Department's finding that access to home health care services during the period 2001-2005 complied with section 30(A).

The case was remanded to the trial court, which issued an order on October 29, 2012, requiring the Department to conduct a further rate review for 2001-2005 for the purpose of further evaluating whether rates were sufficient for beneficiaries to have adequate access consistent with the March 2012 Court of Appeal decision. ~~The Department is currently conducting the further rate review required by the court.~~ **In March 2013, the Department completed a further rate review, in which it determined that the rates paid to HHAs during 2001-2005 were sufficient to comply with the Access requirement of federal Medicaid law. The plaintiffs have filed a motion challenging the validity of the Department's further rate review. They seek a court order to invalidate the rates and to require the Department to pay HHAs damages for the period since 2001 equal to the difference between the rates paid and each HHA's usual and customary charges. The Department is opposing this motion. A court judgment in this matter is expected later in FY 2013-14.**

21. California Hospital Association v. Shewry

The California Hospital Association (Plaintiff) is a trade association representing nursing facilities that are a distinct part of a hospital (DP/NFs). Plaintiff contends the Department's policy of excluding the projected costs of facilities with less than 20% Medi-Cal days in

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determining the median rate results in rates that violate various laws, including 42 U.S.C. section 1396a(a)(30)(A). Plaintiff also contends that the freeze in rates during rate year 2004-05 violated section 1396a(a)(30)(A). Plaintiff seeks an injunction against the continued use of the 20% exclusion policy and a writ of mandate requiring the Department to recalculate rates for rate years 2001-02 through 2005-06 and pay DP/NFs the additional amount owed based on the recalculations.

On August 20, 2010, the Court of Appeal issued a decision reversing the trial court's judgment in favor of the Department. The Court of Appeal held that the Department violated section 1396a(a)(30)(A) by failing to evaluate whether rates were reasonable relative to provider costs. The case has been remanded back to the trial court for further litigation concerning the plaintiff's challenge to the rates paid for rate years 2001-02 through 2005-06. So far, there has been some additional discovery, but no other activity has occurred since the remand.

22. *Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services*

Plaintiffs are 17 hospitals that contend that the 10% Medi-Cal payment reductions the Department implemented for non-contract hospital inpatient services, pursuant to ABX4 5 (Chapter 5, Statutes of 2009), violate various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(8) and 1396a(a)(30), the Supremacy Clause and Equal Protection Clause of the United States Constitution, the State Plan, and state law. The status of the case is as follows:

- On February 20, 2009, the federal court denied plaintiffs' motion for preliminary injunction,
- On June 1, 2009, the Ninth Circuit dismissed the plaintiffs' appeal. Plaintiffs filed an amended motion for preliminary injunction with respect to the 10% payment reductions mandated by W&I Code section 14166.245,
- On November 18, 2009, the district court issued a preliminary injunction with respect to the 10% payment reduction for non-contract hospital inpatient services rendered on or after that date. The Department appealed,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,
- On January 18, 2011, the United States Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy Clause to sue states over whether provider rates comply with 42 U.S.C. section 1396a(a)(30)(A),
- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case back to the Ninth Circuit to reconsider the Department's appeal of the preliminary injunction, and
- Appellate briefing has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

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**INFORMATION ONLY****23. Independent Living Center of Southern California Inc. et al. v. David Maxwell-Jolly**

This lawsuit challenges the 10% reduction required by ABX4 5 (Chapter 5, Statutes of 2009) in Medi-Cal payments that took effect on July 1, 2008. These reductions are mandated by W&I Code sections 14105.19 and 14166.245. Plaintiffs contend that these reductions violate 42 U.S.C. section 1396a(a)(30)(A) and the Americans with Disabilities Act. The status of this case is as follows:

- On August 18, 2008, the district court issued a preliminary injunction against the 10% reduction for physicians, dentists, optometrists, adult day health care centers, clinics, and for prescription drugs for services on or after August 18, 2008,
- On November 17, 2008, the district court issued a preliminary injunction against the 10% reduction for home health and non-emergency medical transportation (NEMT) services for services on or after November 17, 2008,
- On July 9, 2009, the Ninth Circuit issued a decision affirming the district court's August 18, 2008, preliminary injunction. The Ninth Circuit further granted plaintiffs' appeal with respect to their claim that the district court's August 18, 2008, injunction should have applied to service back to July 1, 2008,
- On August 7, 2009, the Ninth Circuit issued a decision affirming the district court's preliminary injunction with respect to NEMT and home health services,
- On January 22, 2010, the district court issued an order requiring the Department to pay additional money due for July 1, 2008 through August 17, 2008 to providers in the 6 categories covered by the August 18, 2008 injunction,
- On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy clause to sue states over whether provider rates comply with 42 U.S.C. section 1396(a)(30)(A)
- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case to the Ninth Circuit to reconsider the Department's appeals of the two injunctions, and further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

**24. AB 1183 Litigation**

Two lawsuits challenged provider payment reductions that were mandated by AB 1183 (Chapter 758, Statutes of 2008) effective October 1, 2008 for non-contract hospital inpatient services, and March 1, 2009 for prescription drugs, adult day health care center (ADHC) services, and other hospital services. The plaintiffs in these cases contend that the reductions violate 42 US Code Section 1396(a)(30)(A).

- In the *Independent Living Center of Southern California (formerly Managed Care Pharmacy) v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on February 26, 2009 against the 5% payment reduction for prescription drugs. The Department appealed.

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- In the *California Pharmacists Association, et al. v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on March 6, 2009 against the 5% payment reduction for ADHC services. The district court denied a preliminary injunction against the AB 1183 payment reductions for hospitals. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit granted the plaintiffs' motion for a stay of the district court's denial of a preliminary injunction concerning the hospital payment reductions, pending their appeal of that ruling, which effectively enjoined the AB 1183 payment reductions for hospitals beginning April 6, 2009.

On March 3, 2010, the Ninth Circuit issued three decisions that affirmed preliminary injunctions against the AB 1183 payment reductions for prescription drugs, ADHC and hospital services. On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy Clause to sue states for violation of section 1396a(a)(30)(A). On February 22, 2012, the Supreme Court issued a ruling that vacated the Ninth Circuit decisions and remanded both cases back to the Ninth Circuit to reconsider the Department's appeals of the three injunctions in the above cases. Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

**25. AB 97 Litigation**

Four lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.

- *California Hospital Association v. Douglas, et al.*

Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011 shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government (Secretary of the Department of Health and Human Services, Kathleen Sebelius), which recently approved a State Plan Amendment (SPA) concerning these reductions, has been named as a co-defendant.

On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. The Department appealed. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011 that were not reimbursed prior to that date. Plaintiffs appealed that ruling. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. ~~On January 28, 2013, the plaintiffs requested a rehearing of the decision.~~ **On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally**

**INFORMATION ONLY****vacating the four court injunctions. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

- *Managed Pharmacy Care, et al. v. Sebelius, et al.*

Plaintiffs, a Medi-Cal beneficiary, five pharmacies, a statewide pharmacy member group, an independent living center, and the state association of independent living centers, challenge the October 27, 2011 action of defendant Secretary of the U.S. Department of Health and Human Services (HHS), approving a SPA of defendant California Department of Health Care Services for a 10% Medi-Cal payment reduction. Plaintiffs allege that Medi-Cal payment reductions mandated by AB 97 (as amended by AB 102) violate requirements set forth in 42 U.S.C. section 1396a(a)(30)(A), and that HHS violated the Federal Administrative Procedure Act in approving the SPA. Plaintiffs also allege violation of the due process clause of the 14<sup>th</sup> Amendment, the Fifth Amendment, and the Privileges and Immunities Clause of the U.S. Constitution.

On December 28, 2011, the district court issued a preliminary injunction against the 10% reduction for prescription drugs. All requests for stay have been denied. On March 12, 2012, the district court issued an order modifying the preliminary injunction to allow the Department to apply the payment reduction for prescription drugs provided to services rendered from June 1, 2011 through December 27, 2011 that are reimbursed for the first time on or after December 28, 2011. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. ~~On January 28, 2013, the plaintiffs requested a rehearing of the decision.~~ **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 AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

- *California Medical Transportation Association v. Douglas, et al.*

Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.

On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. Defendants appealed. Plaintiffs appealed the court's decision allowing some retroactive implementation of the reduction. On

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December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. ~~On January 28, 2013, the plaintiffs requested a rehearing of the decision.~~ **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 AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

- *California Medical Association v. Douglas, et al.*

Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government (Kathleen Sebelius, Secretary of Health and Human Services), which recently approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012 that are not reimbursed at the unreduced rates prior to that date. The Department appealed, and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. ~~On January 28, 2013, the plaintiffs requested a rehearing of the decision.~~ **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 AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

26. *California Hospital Association v. David Maxwell-Jolly*

This lawsuit seeks to enjoin a "freeze" in rates for the 2009-10 rate year (i.e. freeze rates at the 2008-09 rate levels) for hospital based nursing facility and sub-acute care services and the extension to some small and rural hospitals of the 10% reduction for non-contract hospital inpatient services. Plaintiff alleges violations of various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30), and that implementation of these statutory changes is preempted by the Supremacy clause of the United States Constitution.

On February 24, 2010, the district court issued a preliminary injunction against the 10% reduction for small and rural hospitals and the freeze in rates for hospital based nursing facility and sub-acute services. On appeal, the Ninth Circuit granted the Department's motion for a stay of appellate proceedings pending petitions for certiorari in Maxwell-Jolly v,

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Independent Living Centers and Maxwell-Jolly v. California Pharmacists Association. On March 30, 2012, the Ninth Circuit ordered an end to the stay. This case has been referred to non-binding mediation in the Ninth Circuit, so there will be no further briefs submitted by the parties until the mediation is complete.

27. California Association of Rural Health Clinics, et al. v. Maxwell-Jolly

Plaintiffs, an individual Federally Qualified Health Center (FQHC) and an association representing multiple Rural Health Clinics (RHCs), allege that the Department illegally applied the 2009 elimination of certain optional Medi-Cal benefits required by ABX3 5 (Chapter 20, Statutes of 2009) to FQHCs and RHCs. Plaintiffs contend that certain benefits are mandatory when provided by an FQHC and seek to compel the Department to continue to reimburse FQHCs for these services. Plaintiffs contend that W&I Code section 14131.10 is preempted via the Supremacy Clause of the US Constitution as to Departmental payment to FQHCs and RHCs for the provision of these eliminated benefits.

On October 20, 2010, the district court issued an order enjoining the Department from disallowing certain optional benefits to RHCs and FQHCs until the applicable SPA was approved by CMS. Both the Department and Plaintiffs appealed. ~~The SPA was approved by CMS on May 23, 2011. Plaintiffs are still challenging the elimination of optional benefits based on "new evidence" they allege they have discovered. The Department is requesting that this issue be sent back to the district court for consideration. In the meantime, the issue of whether the Department can implement a reduction of services prior to CMS' approval of a SPA remains in front of the Ninth Circuit Court of Appeals.~~ **On May 23, 2011, CMS approved the SPA eliminating the Medi-Cal optional benefits for all providers, including FQHCs and RHCs.**

**On July 5, 2013, the Ninth Circuit Court of Appeals found that the statutory definition of physician services for FQHCs and RHCs includes the eliminated services. Although these services are optional under Medi-Cal, in FQHCs and RHCs, they are mandatory and Medi-Cal must reimburse for them. The Ninth Circuit further found that the Department was obligated to obtain SPA approval before implementing it.**

**The Department has filed a petition for rehearing and rehearing en banc on two grounds, including that the Court's finding that CMS must approve a SPA before its implementation conflicts with CMS's interpretation of its own regulation. The Court ordered Plaintiffs to file a response, which they have done. There is no specific time frame within which the Court must decide the petition.**

28. Managed Care Potential Legal Damages

Four health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate setting methodology for the rate years from 2002 through 2005. The cases are referred to as:

- *Santa Clara County Health Authority dba Santa Clara Family Health Plan v. DHCS*
- *Health Net of California, Inc. v. DHCS*

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- *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
- *Molina Healthcare of California, Inc., v. DHCS*

On April 20, 2011, the trial court issued a judgment in favor of plaintiff Santa Clara County Health Authority and on June 13, 2011, judgment was issued in favor of the plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. **On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit.** The Department is **presently engaged** in appellate mediation on damages and interest for each of these cases, but mediation has not been completed **in the Santa Clara, Blue Cross, and Molina cases.**

On November 2, 2012, the Department and Health Net reached a settlement agreement for capitation rate disputes regarding rate years 2003-04 through 2010-11. In the settlement, Health Net agreed to seek dismissal of its 2006-07 through 2010-11 rate litigation and the Department agreed to seek dismissal in its appeal of the adverse Superior Court ruling in the 2003-04 and 2004-05 rate litigation. Additionally, the Department agreed to extend contracts:

- ~~#03-76182: Extension through March 31, 2019, for Los Angeles County,~~
- ~~#12-89334: A) Extension through June 30, 2020, for San Diego County, B) Extension through December 31, 2018, for Sacramento County, and C) Extension through December 31, 2022, for Kern, Stanislaus, Tulare, and San Joaquin Counties. This is the recently awarded Central Valley Two-Plan Model Commercial Health Plan contract (as evidenced in the Notice of Intent to Award dated May 4, 2012, award such contract to Health Net).~~

~~The Department also agreed to make contract revisions regarding audits, operational efficiencies, and encounter data submissions, as well as the limitations regarding retroactive rate reductions as they pertain to the imposition of copayment policies, elimination of covered benefits and/or services, and/or future DHCS initiated provider rate reductions. The settlement will terminate of its own accord between 2020 and 2023; the Department may be required to make a payment pursuant to the settlement agreement to Health Net at that time.~~

**29. AIDS Healthcare dba Positive Healthcare**

Plaintiff seeks declaratory and injunctive relief to prohibit the Department from complying with W&I Code section 14105.46. The complaint alleges that section 14105.46 violates State and federal law, because that State statute illegally compels AIDS Healthcare Foundation (AHF) to accept payment under the methodology set forth in the federal 340B program for the drugs it provides to persons with HIV and AIDS.

As a result of a Motion to Dismiss filed by the Department, on March 15, 2010, the court dismissed this case in its entirety, with prejudice. Plaintiff ~~filed an appeal and argument was held on October 12, 2011~~ **appealed**. On November 3, 2011, the Ninth Circuit U.S. Court of

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Appeals issued an unpublished decision affirming in part and reversing in part the lower court's dismissal of the case. Plaintiff's claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA ~~will proceed~~ **proceeded**. In October 2012, the U.S. District Court stayed this case pending a ruling in the AB 97 consolidated appeal. On December 13, 2012, the Ninth Circuit Court of Appeal issued a decision in the AB 97 consolidated cases, ~~but the decision is not yet final~~. The Department filed a motion to continue the stay, ~~in the AIDS Healthcare case to be heard on February 25, 2013~~ **but on February 25, 2013, the court lifted the stay.**

**After the stay was lifted, the parties filed cross-motions for summary judgment. On March 18, 2013, the court found in favor of the Department on the Equal Protection claims, but ruled in favor of Plaintiff on their cross-motion for summary judgment on the (a)(30)(A) and SPA approval causes of action. The court held that:**

- **The Department was required to obtain SPA approval prior to implementation and did not do so, and**
- **Neither the legislature nor the Department considered the relevant factors under (a)(30)(A). The court enjoined the Department from implementing the 340B drug program, effective May 3, 2013.**

**The Department has filed a Notice of Appeal with the Ninth Circuit Court of Appeals. The Department's opening brief is due November 12, 2013. Pharmacy staff continue to seek CMS approval of the SPA.**

30. *Darling et al. v. Toby Douglas*

This lawsuit sought to enjoin the elimination of Medi-Cal coverage of adult day health care (ADHC) services, as required by AB 97 (Chapter 3, Statutes of 2011). Plaintiffs contend that elimination of Medi-Cal covered ADHC services violates various federal laws, including the Americans with Disabilities Act. The Department and plaintiffs entered into a settlement agreement, which was approved by the court in January 2012. The settlement ended ADHC services effective ~~February 29, 2012~~ **March 31, 2012**, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective ~~March~~ **April** 1, 2012. The settlement agreement will be in effect until August **31**, 2014, with the court retaining jurisdiction during the pendency of the settlement.

31. *California Association of Health Facilities, et al. v. Toby Douglas*

This lawsuit seeks to enjoin a freeze in the Medi-Cal rates paid to intermediate care facilities for the developmentally disabled (ICF/DDs), including ICF/DD-Hs (habilitative) and ICF/DD-Ns (Nursing), and freestanding pediatric sub-acute care facilities (W&I Code section 14105.191 (f)(2)). Plaintiffs contend that the state violated 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30)(A) in enacting and implementing the rate freeze, and that the freeze statute is therefore preempted by federal law under the supremacy clause of the United States Constitution. The status of the case is as follows:

- On May 6, 2011, the court issued a preliminary injunction against the rate freeze,

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- On June 28, 2011, the United States Court of Appeals (Ninth Circuit) granted the Department request for a stay of the preliminary injunction pending appeal,
- On November 30, 2011, the Ninth Circuit issued a decision reversing the preliminary injunction, and
- On March 21, 2012, the district court granted plaintiffs' motion for leave to amend their complaint to state a claim under the "takings" clause of the Constitution, and to name HHS Secretary Sebelius as a defendant. The district court stayed further litigation pending a decision by the Ninth Circuit on remand in the Independent Living litigation.

**32. California Pharmacists Association v. David Maxwell-Jolly**

This lawsuit challenges the legality of a new upper billing limit provision concerning maximum allowable ingredient costs (MAICs) and the use of recently reduced average wholesale prices (AWPs) in reimbursing drugs. Plaintiffs claim that the State has not complied with 42 U.S.C. section 1396a(a)(30)(A) in enacting and implementing these changes.

On May 5, 2010, the district court issued an order granting preliminary injunction concerning the new upper billing limit and new MAICs, but denying preliminary injunction concerning the AWP reductions. The Department and plaintiff both appealed. On April 2, 2012, the Ninth Circuit lifted a stay of the appellate litigation that had been in effect. The preliminary injunction remains in effect. The Ninth Circuit has postponed appellate court briefing to allow the parties time to first explore possible settlement.

**33. Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly**

This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The third cause of action (duty to review rates annually) was transferred to a different judge to be heard separately from the other two causes of action. Based on the hearing on the third cause of action, the Court ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. The Rate Review was filed with the court on December 16, 2011. On March 15, 2012, the court ordered the parties to proceed on the two remaining causes of action. On April 30, 2012, the Department filed a demurrer to the (a)(30)(A) cause of action. The hearing on the demurrer was held on June 28, 2012, and the demurrer was sustained without leave to amend, which disposed of the second cause of action. ~~The Department intends to file a motion for summary judgment on~~

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the remaining Equal Protection cause of action. **Petitioners then dismissed their equal protection claim.**

**On May 23, 2013, Petitioners moved to enforce the writ, claiming that the Department's rate review was inadequate. At a hearing on June 21, 2013, the Court found that the Department's rate review was generally adequate, but had failed to adequately compare Medi-Cal's rates to those of other third party payers, as required by the statute. The Court set a hearing for October 24, 2013 at which the Department must either submit a revised report or show cause why it should be excused from doing so.**

34. Family Planning Services – Los Angeles County Claims Reviewed by the OIG

The Office of the Inspector General (OIG) plans to conduct an audit of family planning services claimed under the Family PACT program in Los Angeles County. The audit will determine whether the Department complied with Federal and State requirements when claiming Federal reimbursement at the 90% rate for family planning services provided under the Family PACT program. The audit period covers payments made during the period October 1, 2010 through September 30, 2011.

35. Marquez v. California Department of Health Care Services, David Maxwell-Jolly Lawsuit

In this pending litigation, the petitioners seek a writ of mandate that would require the Department to provide a Medi-Cal beneficiary with a due process notice (Notice of Action) and the right to appeal (Fair Hearing) when other health coverage (OHC) is added to a Medi-Cal beneficiary's record. Alternatively, petitioners contend that the Medi-Cal program should change from a cost avoidance system to a "pay and chase" recovery process.

**OTHER: REIMBURSEMENTS**

36. Federal Upper Payment Limit

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

The UPL only applies to private hospitals and non-designated public hospitals that are part of the category of "non-state government-owned hospitals". The UPL for designated public hospitals consists of audited costs.

37. Selective Provider Contracting Program Waiver Renewal

The 1915(b) waiver that authorized the SPCP allowed California to negotiate contracts with hospitals for inpatient services on a competitive basis expired on August 31, 2005. However, the Department was allowed to continue the SPCP under the Medi-Cal

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Hospital/Uninsured Care Demonstration Waiver which ended on October 31, 2010. The BTR Waiver was approved November 1, 2010 for five years and includes continuation of the SPCP.

On July 1, 2013, the Department ~~will implement~~ **implemented** a new payment system, which ~~will replace~~ **replaced** the SPCP and existing non-contract payment system.

**38. Accrual Costs Under Generally Accepted Accounting Principles**

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to accrual. For the most recently completed fiscal year (FY ~~2011-12~~ **2012-13**), the June 30, ~~2012~~ **2013** Medi-Cal accrual amounts were estimated to be \$1.95 **\$2.23** billion state General Fund, and \$7.42 **\$5.09** billion federal funds, **and \$1.47 billion special fund**, for a total of ~~\$9.37~~ **\$8.79** billion.

**39. Freestanding Clinic – Former Agnews State Hospital**

The 2003-04 Governor's Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

The Department has obtained approval from CMS to amend the State Plan to establish a cost-based reimbursement methodology for the freestanding clinic beginning April 1, 2009.

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

**40. Refund of Recovery**

CMS requested the Department prepare reconciliations of Grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery

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activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of \$240 million FFP for federal FY 2007 through 2011 and \$34 million FFP ongoing each month.

**OTHER: RECOVERIES**

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated into Base Data/Ongoing

#### ELIGIBILITY

##### 1. Lomeli, et al., v. Shewry

The Department finalized a settlement of the *Lomeli, et al., v. Shewry* lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. As a result, the Department sends notices to new SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and new SSI recipients, informing them of the availability of retroactive coverage.

#### BENEFITS

##### 1. Family PACT Retroactive Eligibility

Effective April 1, 2011, Medi-Cal allows retroactive eligibility for Family PACT qualifying clients for up to three months prior to the first day of the month of application to the Family PACT program.

The Department implemented the following:

- Retroactive eligibility certification procedure,
- Claim process for newly-enrolled clients, and
- Procedures to ensure reimbursement for retroactive period.

#### HOME & COMMUNITY-BASED SERVICES

#### BREAST AND CERVICAL CANCER

#### PHARMACY

##### 1. Sunset of Specialty Drug Contracts

Assembly Bill (AB) 1183 (Chapter 758, Statutes of 2008) allowed the Department to enter into contracts with providers who distribute and provide care for specialty drugs and services. This provision allows the Department to restrict payment of specialty drugs and services to a limited number of providers. The legislation included a sunset provision of July 1, 2013.

Under AB 102 (Chapter 28, Statutes of 2011), the Actual Acquisition Cost (AAC) Medi-Cal pharmacy payment methodology was established. This payment methodology includes a provision to identify specialty drugs by means of a provider survey of services and costs and

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## DISCONTINUED ASSUMPTIONS

### Fully Incorporated into Base Data/Ongoing

by means of the contracting provisions of W&I Code 14105.3, in order to provide an enhanced fee for services associated with the provision of specialty drugs and services.

If the sunset occurs, the Department will lose its mechanism for reimbursing pharmacy providers for specialty drug services. Beneficiaries in need of these services would be forced to access them through more costly acute care or long-term care providers.

The Department is proposing Trailer Bill Language to eliminate this sunset date.

#### 2. Physician-Administered Drug Reimbursement

SB 853 (Chapter 717, Statutes of 2010) established a new reimbursement rate methodology for physician-administered drugs to be reimbursed consistent with the Medicare rate of reimbursement or the pharmacy rate when the Medicare rate is not available. The new rates were implemented on September 1, 2012, with savings being generated under this methodology.

Erroneous Payment Corrections will be performed for the period of September 1, 2011 through August 31, 2012 on all claims that were reimbursed under the old methodology.

### 1115 WAIVER—MH/UCD & BTR

#### MANAGED CARE

##### 1. Managed Care Cost-Based Reimbursement Clinics (CBRC)

The Department is required to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. Currently, tentative settlements are prepared by the Department after review of reconciliation requests and final settlements or recoveries are invoiced within three years after the submission of the original reconciliation reports.

Effective July 1, 2011, CBRCs that provide services to Seniors and Persons with Disabilities (SPDs) who reside in Los Angeles County and are enrolled in managed care plans will be reimbursed through managed care capitation rates.

##### 2. Align Managed Care Benefit Policies

Medi-Cal covers the cost of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. Previously, the COHS were responsible for covering the cost of the retroactive period and they received an adjustment in their capitation rates for this cost. The Two-Plan and Geographic Managed Care health plans are not responsible to cover the costs of their enrollees during the retroactive period.

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**DISCONTINUED ASSUMPTIONS****Fully Incorporated into Base Data/Ongoing**

Instead, these costs are paid in FFS. Effective July 1, 2012, the Department eliminated the COHS' responsibility for the retroactive period and shifted this cost to FFS.

**3. Potentially Preventable Admission**

The Department analyzed historical encounter data to identify situations where an inpatient admission was potentially preventable and quantified the level of inefficiency and/or potentially avoidable expenses present in the base data for managed care plans. Based on the analysis, the Department imposed an adjustment to Medi-Cal Managed Care rates to account for potentially preventable admissions into hospital inpatient facilities.

**PROVIDER RATES****SUPPLEMENTAL PAYMENTS****OTHER: AUDITS AND LAWSUITS****OTHER: REIMBURSEMENTS****OTHER: RECOVERIES****FISCAL INTERMEDIARY: MEDICAL****FISCAL INTERMEDIARY: HEALTH CARE OPTIONS****1. Health Plan of San Joaquin Replacing Anthem Blue Cross as LI in Stanislaus County**

Previously, Stanislaus County designated Anthem Blue Cross as the Local Initiative (LI) health plan. Beginning January 1, 2013, Health Plan of San Joaquin (HPSJ) became the new designated LI through a request for proposal. In September 2012, the Department mailed notices and packets to all beneficiaries. The mailing coincided with the HPSJ start date of January 1, 2013.

**FISCAL INTERMEDIARY: DENTAL**

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**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available****ELIGIBILITY**1. Outreach – Children

The Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997) established funding for children's outreach. Activities included media, public relations, collateral, certified application assistance, and a toll-free line.

In the Budget Act of 2003, outreach was limited to funding of a toll-free line. An interagency agreement with MRMIB was executed to fund the toll-free line with MAXIMUS starting January 1, 2004.

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. The Department will continue to fund the toll-free line, but the interagency agreement with MRMIB will be terminated in FY 2012-13.

2. Lomeli, et al., v. Shewry

The Department finalized a settlement of the *Lomeli, et al., v. Shewry* lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. As a result, the Department sends notices to new SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and new SSI recipients, informing them of the availability of retroactive coverage.

3. Bridge to HFP

The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost (SOC) Medi Cal or are eligible for Medi-Cal with a SOC. To be eligible for this Bridge, a child must have income at or below the Healthy Families income standard of 200% of poverty (although the use of an income disregard effectively raises the upper limit to 250% of poverty). Title XXI federal funding is used for this additional coverage. Medi-Cal managed care plan members remain enrolled in the managed care plan during the one month of additional eligibility. Plans receive an additional capitation payment for each of these member months.

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology, which reduces the need for the bridge from Medi-Cal to the HFP.

4. Reduction of CNI-Based COLA to Counties

The Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated for FY 2012-13.

## **DISCONTINUED ASSUMPTIONS**

### **Time Limited/No Longer Available**

#### **AFFORDABLE CARE ACT**

#### **BENEFITS**

#### **HOME & COMMUNITY-BASED SERVICES**

#### **BREAST AND CERVICAL CANCER**

#### **PHARMACY**

#### **MENTAL HEALTH**

##### 1. Specialty Mental Health Lawsuits

Three Los Angeles MHPs have filed a writ of mandate requesting the court to direct the Department to approve certain Specialty Mental Health claims from FY 1999-00 and FY 2000-01. The cases are referred to as:

- Hillside Home for Children, et al. v. California, et al,
- Hathaway-Sycamores Child and Family Services, et al. v. California, et al, and
- Five Acres v. California, et al

The claims were denied for various reasons including lack of Medi-Cal eligibility on the date of service. A proposed settlement agreement provides for Los Angeles County to pay the providers for the claims, certify the public expenditures, and submit the claims to the Department for FFP.

#### **1115 WAIVER—MH/UCD & BTR**

##### 1. MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA

ARRA temporarily increased California's FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The annual SNCP federal funds allotment increased accordingly. This increase in federal funds was claimed by the State through the Safety Net Care Pool via certified public expenditures. Effective November 1, 2010, under the BTR, this federal flexibility funding is no longer applicable.

Interim claims were completed in FY 2010-11. The Department will conduct the final reconciliation for Demonstration Year 5 in FY 2012-13.

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## DISCONTINUED ASSUMPTIONS

### Time Limited/No Longer Available

#### 2. MH/UCD—Health Care Coverage Initiative – Administrative Costs

FFP is available for costs incurred on or after March 29, 2007 through October 31, 2010, that are associated with the start-up, implementation and closeout administration of approved CI programs. The federal funds will reimburse the CI counties an amount equal to 50% of their CPEs for administrative costs. The administrative activities for which FFP is being requested were submitted to CMS on December 22, 2006, and approved in October 2007.

The required administrative cost claiming protocol was approved by CMS in October 2008 for prospective costs after the implementation of the time study. The Department implemented the time study in February 2009 for prospective costs and began reimbursement to the CI counties in FY 2009-10. The Department received CMS approval in August 2010 for the cost claiming methodologies for the administrative costs for the period prior to the implementation of the time study, along with the start-up and close-out costs. Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the Low Income Health Program. See assumption BTR-Low Income Health Program – Administrative Costs for more information.

#### 3. MH/UCD—Distressed Hospital Fund

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, “distressed hospitals” receive supplemental payments from the Distressed Hospital Fund, Item 4260-601-8033. SB 1100 requires the transfer of 20 percent per year over five years of the balance of the prior supplemental funds, including the ESSP Fund (SB 1255/VGT), (Item 4260-601-0693), the Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0550), the Large Teaching Emphasis Hospital and Children’s Hospital Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0549), and the Small and Rural Hospital Supplemental Payments Fund (Item 4260-601-0688), to the Distressed Hospital Fund. Contract hospitals that meet the following requirements, as determined by the Department, are eligible for distressed funds:

- The hospital serves a substantial volume of Medi-Cal patients.
- The hospital is a critical component of the Medi-Cal program’s health care delivery system.
- The hospital is facing a significant financial hardship.

On October 31, 2010, funding for the Distressed Hospital Fund ended with the expiration of the MH/UCD waiver and no separate funding is allocated under the BTR. Any residual balances from the above four prior supplemental funds are expected to be paid from the Distressed Hospital Fund in FY 2012-13.

The stabilization funding amounts to the Distressed Hospital Fund will be determined following the completion of the final reconciliations of the interim Medicaid inpatient hospital

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**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available**

payment rates, interim DSH payments, and interim SNCP payments for each FY under the MH/UCD and budgeted in the Stabilization Funding policy change.

**MANAGED CARE****1. Increase in Capitation Rates for Gross Premium Tax**

AB 1422 (Chapter 157, Statutes of 2009) has imposed a Gross Premium Tax on the total operating revenue of Medi-Cal Managed Care plans. 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 proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. The provision pertaining to this tax is effective retroactively to January 1, 2009. The Gross Premium Tax sunsetted on June 30, 2012. The Department has proposed legislation to extend the tax through June 30, 2014. Managed Care plans affected by this new legislation are:

- Two Plan Model
- County Organization Health Systems
- Geographic Managed Care
- AIDS Healthcare Centers  
SCAN

**2. Funding Adjustment of Gross Premium Tax Funds to GF**

AB 1422 (Chapter 157, Statutes of 2009) imposed an additional tax on the total operating revenue of Medi-Cal Managed Care Organizations (MCOs). The taxes are then placed in a special tax fund and are used to increase the capitation rates to reimburse the cost of the tax to the plans.

Capitation rate increases due to the tax are initially paid from the General Fund. The Department then requests quarterly reimbursement of the General Fund through a funding adjustment from the Tax Fund.

**3. Retroactive Managed Care Rate Adjustments for FY 2011-12**

CMS did not approve managed care rate adjustments for FY 2011-12 in time to be paid in FY 2011-12. These adjustments will be paid in FY 2012-13. The Department will develop and CMS will approve future fiscal year managed care rate adjustments in time so that they may be paid in the same fiscal year.

**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available****PROVIDER RATES**1. 10% Payment Reduction Restoration and Supplemental Payments

Under ABX1 19 (Chapter 4, Statutes of 2011), the 10% payment reduction for AB 1629 facilities ended July 31, 2012. ABX1 19 requires the Department to:

- Provide a one-time supplemental payment in FY 2012-13 that is equivalent to the reduction applied from May 1, 2012 through July 31, 2012,
- Provide an allowable rate increase up to 2.4% for the 2011-12 rate year. Under ABX1 19, a rate adjustment of 0.426% was provided for the 2011-12 rate year.

AB 1489 (Chapter 631, Statutes of 2012) freezes rates and eliminates the hold harmless for 2012-13 rate year and provides a 3% rate increase in 2013-14 and 2014-15.

2. Eliminate 2012-13 Rate Increase & Supp. Payment

AB 1489 (Chapter 631, Statutes of 2012) authorizes the Department to:

- Redirect funding for rate increases and the Quality and Accountability Payments Program supplemental payments for AB 1629 facilities to the GF in 2012-13, and
- Allow for the savings associated with the Professional Liability Insurance (PLI) cost category capped at the 75<sup>th</sup> percentile to remain in the General Fund rather than being transferred to the Quality and Accountability Supplemental Payment (QASP) Fund.

**SUPPLEMENTAL PAYMENTS****OTHER: AUDITS AND LAWSUITS****OTHER: REIMBURSEMENTS**1. FI Cost Containment Projects – Program Savings

The Department has approved implementation of proposals developed by the Fiscal Intermediary to contain Medi-Cal costs. The cost containment proposals result in savings to the Medi-Cal program. The Fiscal Intermediary will share in the achieved savings for two years after implementation of each proposal.

2. Cost Shift of CCS State-Only to Medi-Cal EPC

In June 2012, the Department identified payment problems for CCS State-Only services:

- The system erroneously paid Medi-Cal claims with CCS State-Only GF and matching County funds instead of Medi-Cal funds.
- The system denied claims that should have been approved for payment.

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**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available**

The Department is currently completing the first stage of the Erroneous Payment Correction (EPC) to adjust the funding shift.

**OTHER: RECOVERIES****FISCAL INTERMEDIARY: MEDICAL****1. Extension of the HP Contract**

The Department contracts with HP up to June 30, 2012 to allow for the completion of all post operation activities. The Department extended the HP contract one year, up to June 30, 2013, for the sole purpose of providing payment to HP for a cost containment proposal. The payment is for services performed during the original term of the contract.

**2. CA-MMIS Takeover by New FI Contractor**

CA-MMIS is the claims processing system used for Medi-Cal and is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The Department extended the term of the previous contract to June 30, 2012 to continue uninterrupted support of operations until a successful Assumption of Operations (AOO) by the new FI contractor's Takeover phase. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published on December 8, 2009. The Takeover activities of the new FI contractor began on May 3, 2010. In the Takeover Phase, the new FI completed contractually required activities necessary for the AOO from the previous contractor. These activities include the following expansion items:

- On-line and Computer-Based Interactive Training,
- Post-Service Prepayment Audit,
- Contingency Payments,
- Caller Satisfaction Evaluation Tool,
- Encounter Data Processing,
- Geographic Mapping,
- Contract Management,
- CA-MMIS Enterprise Project Management Office,
- Project and Portfolio Management,
- Additional Software Licenses,
- Additional Office Space,
- Security for Data "At Rest",
- Additional 32-Bit Processors,
- Payment Methodology Modification,
- Sensitive Information Redaction.

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**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available**

Takeover plans were completed in FY 2011-12; however, final documentation and payment for Takeover will occur in FY 2012-13.

**3. HIPAA UPN Exception Request**

Implementation of the original scope of the Universal Product Number (UPN) pilot project was cancelled in March of 2006 because it was determined that the modifications to the current CA-MMIS infrastructure would be too costly and could not be implemented in an efficient manner. Further analysis determined that in order to implement the use of the UPN into a claims processing environment, it would be necessary to bring forth new technology in order to allow for the system to be flexible, cost effective, and easily modified for future requirements.

The Department received 90% funding approval from CMS to revise the scope of the UPN pilot in order to reduce costs and to leverage system changes needed to comply with the Federal Deficit Reduction Act of 2005 which mandates the collection of rebates for physician administered drugs using the National Drug Code (NDC). CMS is requiring a two-year evaluation of the project to substantiate the possible adoption of the UPN as a HIPAA standard. The Department completed the two-year evaluation of the UPN and submitted findings to CMS in September 2011. There will be a FY 2012-13 cost if the Federal government requires the Department to discontinue the use of the UPN.

**4. Cost Containment Proposals – Savings Sharing**

The Department continues to review and approve the Fiscal Intermediary-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with the Fiscal Intermediary continuing to receive a share of the savings.

Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS****FISCAL INTERMEDIARY: DENTAL**

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**DISCONTINUED ASSUMPTIONS****Withdrawn****AFFORDABLE CARE ACT****ELIGIBILITY****BENEFITS**1. **Physician and Clinic Seven Visits Soft Cap**

AB 97 (Chapter 3, Statutes of 2011) caps the number of physician visits and clinic visits (including visits at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)) at seven per fiscal year per Medi-Cal beneficiary. Visits that meet one of the five exception circumstances are not counted in the seven-visit cap. This cap applies to adults 21 years of age or older, except those in nursing facilities, pregnant women, presumptive eligibility and FPACT beneficiaries. The cap applies only to Medi-Cal fee-for-service (FFS); managed care plans already control utilization more tightly than the cap process.

**HOME & COMMUNITY-BASED SERVICES****BREAST AND CERVICAL CANCER****PHARMACY****1115 WAIVER—MH/UCD & BTR****MANAGED CARE**1. **Enrollment Stabilization Program**

The Department is proposing legislation to stabilize managed care enrollment. Managed care enrollees in Two-Plan and Geographic Managed Care counties would be able to switch plans once a year rather than every month. New beneficiaries will have a 90-day period from their initial enrollment date to select or change their managed care plan. On an annual basis, existing members will be provided a 60-day period to change plans.

Notices and packets will be mailed to beneficiaries to inform them of changes in the enrollment policy.

**PROVIDER RATES****SUPPLEMENTAL PAYMENTS****OTHER: AUDITS AND LAWSUITS**

**DISCONTINUED ASSUMPTIONS****Withdrawn****OTHER: REIMBURSEMENTS**1. Operational Flexibilities

The Department will establish policies to improve Medi-Cal processes through operational flexibilities.

**OTHER: RECOVERIES****FISCAL INTERMEDIARY: MEDICAL****FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**1. Health Care Options Consultant Costs

The Department will contract with a health care consultant to develop policies, make recommendations, and provide assistance in aligning its Health Care Options Program with Health Care Reform and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) solution.

Operations for the current enrollment broker contacts ends on September 30, 2012, with three one-year extension options. The Department exercised a one-time extension option of the current contract for the period of September 30, 2012 through September 30, 2013.

**FISCAL INTERMEDIARY: DENTAL**

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**ACRONYMS AND ABBREVIATIONS****A**

A&I	Audits and Investigations Division
AAC	Average Acquisition Cost
AAP	Adoption Assistance Program
AB	Assembly Bill
ABD	Aged, Blind & Disabled
ACA	Affordable Care Act
ACL	Adjudicated Claim Line
ACMS	Automated Collection Management System
ACS	Affiliated Computer Services
ACSL	Adjudicated Claim Service Line
ACSSs/Enh.	Additional Contract Services/Enhancements
ACWDL	All-County Welfare Directors Letter
ADHC	Adult Day Health Care
ADRC	Aging and Disability Resource Connection
AEVS	Automated Eligibility Verification System
AFDC	Aid to Families with Dependent Children
AFLP	Adolescent and Family Life Program
AH	Acute Hospitals
AHF	AIDS Health Care Foundation (aka Positive Healthcare Services)
AI/AN	American Indian/Alaska Native
ALWPP	Assisted Living Waiver Pilot Project
AMP	Average Manufacturer Price
AOO	Assumption of Operations
APD	Advance Planning Document
APS	Adult Protective Services
ARRA	American Recovery and Reinvestment Act of 2009
ASPPP	Adolescent Sibling Pregnancy Prevention Program
AV	Administrative Vendor
AWP	Average Wholesale Price

**B**

BA	Base Adjustment
BBA	Balanced Budget Act of 1997
BCCTP	Breast and Cervical Cancer Treatment Program
BIC	Benefits Identification Card
BIH	Black Infant Health
BIPA	Benefits Improvement and Protection Act of 2000
BTR	California Bridge to Reform Demonstration
BSA	Bureau of State Audits
BY	Budget Year

**C**

CA	County Administration
CA-EV/CMS	California Eligibility Verification/Claims Management System
CAHF	California Association of Health Facilities
Cal-COBRA	California Consolidated Omnibus Budget Reconciliation Act
CalHEERS	California Healthcare Eligibility, Enrollment and Retention System

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CalWIN	CalWORKS Information Network
CalWORKs	California Work Opportunity and Responsibility to Kids
CA-MMIS	California Medicaid Management Information System
CANHR	California Advocates for Nursing Home Reform
CBRC	Cost-Based Reimbursement Clinic
CCFC	California Children and Families Commission (Proposition 10)
CCAHA	Central Coast Alliance for Health
CCM	Coordinated Care Management
CCR	California Code of Regulations
CCS	California Children's Services
CCT	California Community Transitions
CCSAS	California Child Support Automation System
CDA	California Department of Aging
CDADP	California Department of Alcohol and Drug Programs
CDDS	California Department of Developmental Services
CDL	Contract Drug List
CDMH	California Department of Mental Health
CD-MMIS	California Dental Medicaid Management Information System
CDOF	California Department of Finance
CDP	Capital Debt Projects
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CEI	Center for Elders Independence
CESD	Community Elder Care of San Diego
CFCO	Community First Choice Option
CHCF	California Health Care Foundation
CHDP	Child Health and Disability Prevention
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CI	Coverage Initiative (Health Care Coverage Initiative)
CIN	Client Identification Number
C-IV	Consortium IV
CLPP	Childhood Lead Poisoning Prevention
CMAC	California Medical Assistance Commission
CMAS	California Multiple Award Schedule
CMC	Computer Media Claims
CMIPS	Case Management Information and Payroll System
CMS	Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration)
CMS Net	Children's Medical Services Network
CMSB	Children's Medical Services Branch
CMSP	County Medical Services Program
CNI	California Necessities Index
CO	Change Order
COBRA	Consolidated Omnibus Budget Reconciliation Act
COHS	County Organized Health System
COLA	Cost of Living Adjustment
CPE	Certified Public Expenditure
CPI	Consumer Price Index
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CRCS	Cost Reimbursement and Comparison Schedule
CSBG	County Services Block Grant
CTPS	Cigarette and Tobacco Products Surtax (Proposition 99)
CVSO	County Veterans Services Officer

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CWD	County Welfare Department
CWDP	California Working Disabled Program
CWS/CMS	Child Welfare Services/Case Management Services
CY	Current Year

**D**

DAH	Direct Access to Housing
DC	Developmental Center
DHCS	California Department of Health Care Services
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMO	Disease Management Organizations
DOS	Date of Service
DPH	Designated Public Hospital
DP-NF	Distinct Part-Nursing Facility
DRA	Deficit Reduction Act of 2005
DRTS	Drug Rebate Tracking System
DSH	Disproportionate Share Hospitals
DSHP	Designated State Health Program
DSRIP	Delivery System Reform Incentive Pool
DUR	Drug Utilization Review
DY	Demonstration Year

**E**

EAC	Estimated Acquisition Cost
EDS	Electronic Data Systems
EDU	Encounter Data Unit
EHR	Electronic Health Records
EMBER	Enhanced Medi-Cal Budget Estimate Redesign
EPC	Erroneous Payment Collection
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQROA	Estimated Quarterly Rebate Offset Amount
ES	Eligibility Specialist
ESR	Enrollment Service Representative
ESSP	Emergency Services and Supplemental Payments (Fund)
e-TAR	Electronic Treatment Authorization Request
EW	Eligibility Worker

**F**

FAME	Fiscal Intermediary Access to Medi-Cal Eligibility
FDA	Food and Drug Administration
FDB	First Data Bank
FFP	Federal Financial Participation
FFS	Fee-for-Service
FI	Fiscal Intermediary
FMAP	Federal Medical Assistance Percentage
FMP	Family Mosaic Project
FOAG	Field Office Automation Group
Family PACT	Family Planning, Access, Care and Treatment
FPL	Federal Poverty Level

FQHC	Federally Qualified Health Center
FS	Free Standing
FSR	Feasibility Study Report
FUL	Federal Upper Limit
FY	Fiscal Year

**G**

GDB	Genetic Disease Branch
GEMT	Ground Emergency Medical Transportation
GHPP	Genetically Handicapped Persons Program
GMC	Geographic Managed Care
GME	Graduate Medical Education

**H**

HBEX	Health Benefit Exchange
HCBSW	Home and Community Based Services Waiver
HCCI	Health Care Coverage Initiative
HCERA	Health Care and Education Reconciliation Act of 2010
HCFA	Health Care Financing Administration (now Centers for Medicare and Medicaid Services)
HCO	Health Care Options
HCPCS	Healthcare Common Procedures Coding System
HCSF	Health Care Support Fund
HFP	Healthy Families Program
HHSDC	Health and Human Services Data Center
HICL	Hierarchical Ingredient Code Listing
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPP	Health Insurance Premium Payment
HITECH	Health Information Technology for Economic and Clinical Health
HIT IAPD	Health Information Technology Plan and the Implementation Advanced Planning Document
HIT PAPD	Health Information Technology Planning – Advanced Planning Document
HMO	Health Maintenance Organization
HQARF	Hospital Quality Assurance Revenue Fund
HPSM	Health Plan of San Mateo
HQARF	Hospital Quality Assurance Revenue Fund
HR	House Resolution
H&S	Health and Safety

**I**

I&E	Information & Education
IA	Interagency Agreement
IAPD	Implementation Advanced Planning Document
ICF-DD	Intermediate Care Facility - Developmentally Disabled
IEVS	Income and Eligibility Verification System
IFB	Invitation for Bid
IGT	Intergovernmental Transfer
IHC	Indian Health Clinic
IHMC	In-Home Medical Care

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IHO	In-Home Operations
IHS	Indian Health Services
IHSS	In-Home Supportive Services
IMD	Institutions for Mental Diseases
INS	Immigration and Naturalization Service
INP	Individual Nurse Provider
IOD	Image on Demand
IPO	Independence Plus Option
IPOC	Independent Project Oversight Consultant
IPW	Independence Plus Waiver
IRCA	Immigration Reform and Control Act
ISAWS	Interim Statewide Automated Welfare System
IVR	Interactive Voice Response
IV&V	Independent Verification and Validation

**K**

KinGAP	Kinship Guardianship Assistance Payment
KT/PT	Kidney Transplant/Pancreas Transplant

**L**

LAJH	Los Angeles Jewish Homes
LAN/WAN	Local Area Network/Wide Area Network
LDC	Lanterman Developmental Center
LEA	Local Education Agency
LEADER	Los Angeles Eligibility Automated Determination Evaluation and Reporting System
LEC	Local Educational Consortium
LGA	Local Governmental Agency
LI	Local Initiative
LIHP	Low Income Health Program
LIS	Low Income Subsidy
List	List of Contract Drugs (Medi-Cal Drug Formulary)
LOC	Level of Care
LT-AB	Medically Needy Long-Term Care - Blind
LT-ATD	Medically Needy Long-Term Care - Disabled
LTC	Long-Term Care
LTCI	Center for Long-Term Care Integration
LT-OAS	Medically Needy Long-Term Care - Aged

**M**

MAA	Medi-Cal Administrative Activities
MAC	Maximum Acquisition Cost
MAGI	Modified Adjusted Gross Income
MAGIC	Merced Automated Global Information Control
MAIC	Maximum Allowable Ingredient Cost
MA/SNP	Medical Advantage/Special Needs Program
MAXSTAR	Maximus' proprietary case management software
MCE	Medicaid Coverage Expansion
MCHIP	Medicaid Children's Health Insurance Program
MCM	Medical Case Management
MCO	Managed Care Organization

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MEBIL	Medi-Cal Eligibility Information Letter
MEDS	Medi-Cal Eligibility Data System
MEI	Medicare Economic Index
MESH	Medi-Cal Extra-Net for Statewide Health Care
MFP	Money Follows the Person
MHP	Mental Health Plan
MH/UCD	Medi-Cal Hospital/Uninsured Care Demonstration
MI-ADULT	Medically Indigent Adult
MI-CHILD	Medically Indigent Child
MIP	Male Involvement Program
MIPA	Medi-Cal Inpatient Payment Adjustment
MIPPA	Medicare Improvement for Patients and Providers Act
MIS/DSS	Management Information System and Decision Support System
MITA	Medicaid Information Technology Architecture
MLRC	Multi-Level Retirement Community
MMA	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act)
MMCD	Medi-Cal Managed Care Division
MN	Medically Needy
MN-AB	Medically Needy - Blind
MN-AFDC	Medically Needy - Families
MN-ATD	Medically Needy - Disabled
MN-OAS	Medically Needy - Aged
MOA	Memorandum of Agreement
MOE	Maintenance of Effort
MRMIB	Managed Risk Medical Insurance Board
MSRP	Manufacturer Suggested Retail Price
MSSP	Multipurpose Senior Services Program
MTP	Manual Transformation Program

**N**

NDC	National Drug Code
NDPH	Non-Designated Public Hospital
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NF-A	Nursing Facility - Level A
NF-B	Nursing Facility - Level B
NF/AH	Nursing Facility/Acute Hospital
NLDC	No Longer Disabled Children
NOA	Notice of Action
NPP	Notice of Privacy Practices
NPRM	Notice of Proposed Rule Making

**O**

OA	Other Administration
OBRA	Omnibus Budget Reconciliation Act
OCS	Optional Contractual Service
OHC	Other Health Coverage
OIG	Office of the Inspector General
OIL	Operating Instruction Letter
OMDS	Office of Medi-Cal Dental Services

OO	Object Oriented
OSI	Office of System Integration
OTC	Over-the-Counter
OTROS	Office of Technology Review, Oversight and Security

**P**

PA-AB	SSI/SSP Cash Grant - Blind
PA-AFDC	CalWORKs or Foster Care Cash Grant
PA-ATD	SSI/SSP Cash Grant - Disabled
PACE	Program of All-Inclusive Care for the Elderly
PAN	Payment Action Notice
PA-OAS	SSSI/SSP Cash Grant – Aged
PARIS	Public Assistance Reporting and Information Systems
PASARR	Preadmission Screening and Annual Resident Review
PBM	Pharmacy Benefit Manager
PC	Policy Change
PCAB	Proposed County Administrative Budget
PCCM	Primary Care Case Management
PCES	Paid Claims and Encounters Standardization
PCG	Prenatal Care Guidance
PCSP	Personal Care Services Program
PE	Presumptive Eligibility
PERM	Payment Error Rate Measurement
PFSW	Patient Financial Services Worker
PHC	Partnership HealthPlan of California
PHMS	Public Health Monitoring System
PHP	Prepaid Health Plan
PIA	Prison Industry Authority
PIER	Post Implementation Evaluation Report
P.L.	Public Law
PMPM	Per Member Per Month
POE	Perinatal Outreach and Education
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act of 2010
PPC	Pediatric Palliative Care
PPI	Proton Pump Inhibitor
PPS	Prospective Payment System
Prop. 99	Proposition 99 (Cigarette and Tobacco Products Surtax)
PRUCOL	Permanently Residing (in the United States) Under Color of Law
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
PSD	Payment Systems Division
PSF	Prior Settlement Fund
PTN	Provider Telecommunications Network

**Q**

QAF	Quality Assurance Fee
QI	Qualifying Individual
QI-1	Qualifying Individual - Program 1
QI-2	Qualifying Individual - Program 2
QIF	Quality Improvement Assessment Fee
QMB	Qualified Medicare Beneficiary

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QoL	Quality of Life
QROA	Quarterly Rebate Offset Amount
QSR	Quarterly Status Report

**R**

RAD	Remittance Advice Detail
RAIS	Rebate Accounting and Information System
REF_NO	Reference Number
RCFE	Residential Care Facilities for the Elderly
RFP	Request for Proposal
RHC	Rural Health Clinic
RMA	Refugee Medical Assistance
ROP	Reasonable Opportunity Period
RPU	Rebate Per Unit
RRP	Refugee Resettlement Program

**S**

SAVE	Systematic Alien Verification Entitlement
SAWS	Statewide Automated Welfare System
SB	Senate Bill
SBI	Substance Abuse and Brief Intervention
SBRHA	Santa Barbara Regional Health Authority
SCAN	Senior Care Action Network
SCHIP	State Children's Health Insurance Program
SCO	State Controller's Office
SDN	System Development Notice
SDS	Self-Directed Services
SF CLSW	San Francisco Community-Living Support Waiver
SFIS	Statewide Fingerprint Imaging System
SFY	State Fiscal Year
SG	Systems Group
SHMO	Social Health Maintenance Organization
SIR System	Special Incident Reporting System
SLAMSP	South Los Angeles Medical Services Preservation
SLMB	Specified Low-Income Medicare Beneficiary
SMA	Schedule of Maximum Allowances
SMAA	School-Based Medi-Cal Administrative Activities
SMI	Serious Mental Illness
SNCP	Safety Net Care Pool
SNF	Skilled Nursing Facility
SNT	Special Needs Trust
SOC	Share of Cost
SOS	Scope of Services
SOSF	State Operated Small Facility
SOW	Scope of Work
SPA	State Plan Amendment
SPCP	Selective Provider Contracting Program
SPDs	Seniors and Persons with Disabilities
SPE	Single Point of Entry
SPM	Statewide Project Management
SPPCS	State Plan Personal Care Services

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SPR	Special Project Report
SRH	Small Rural Hospitals
SRL	Supplemental Report Language
SSA	Social Security Administration
SSI/SSP	Supplemental Security Income/State Supplementary Payment
STI	Sexually Transmitted Infection
STO	State Treasurer's Office
SURGE	Service Utilization Review Guidance and Evaluation
SURS	Surveillance and Utilization Review Subsystem

**T**

TANF	Temporary Assistance for Needy Families
TAR	Treatment Authorization Request
TBL	Trailer Bill Language
TCM	Targeted Case Management
TCR	Therapeutic Category Review
TIC	Transitional Inpatient Care
TMC	Transitional Medi-Cal
TPL	Third Party Liability
TTG	Toll-Free Telephone Group

**U**

UBL	Upper Billing Limitation
UCSD	University of California, San Diego
UPL	Upper Payment Limit
UPN	Universal Product Number
USPSTF	United States Preventative Services Task Force

**V**

VFC	Vaccines for Children Program
VG	Voluntary Governmental Transfer

**W**

WAC	Wholesale Acquisition Cost
WCDS	Welfare Client Data System
W&I	Welfare and Institutions
WIC	Women, Infants and Children
WPCS	Waiver Personal Care Services
WRIM	Welfare Reform and Infrastructure Modifications
WSP	Wholesale Sale Price