May 2014 Medi-Cal Estimate

Current Year (FY 2013-14) Projected Expenditures Compared to the November 2013 Estimate

(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 November 2013 Estimate are as follows:

Medical Care Services	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$65,641.0	$58,665.0	($6,976.0)	-10.6%
Federal Funds	$40,559.8	$36,862.1	($3,697.7)	-9.1%
General Fund	**$15,294.2**	**$15,627.0**	**$332.8**	**2.2%**
Other Non-Federal Funds	$9,787.0	$6,175.9	($3,611.1)	-36.9%

County Administration	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$3,622.5	$3,282.3	($340.2)	-9.4%
Federal Funds	$2,798.7	$2,376.1	($422.6)	-15.1%
General Fund	**$794.3**	**$878.4**	**$84.1**	**10.6%**
Other Non-Federal Funds	$29.5	$27.8	($1.7)	-5.8%

Fiscal Intermediary	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$414.3	$424.7	$10.4	2.5%
Federal Funds	$272.7	$283.2	$10.5	3.9%
General Fund	**$141.4**	**$141.4**	**$0.0**	**0.0%**
Other Non-Federal Funds	$0.2	$0.1	($0.1)	-50.0%

Total Expenditures	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$69,677.7	$62,372.1	($7,305.7)	-10.5%
Federal Funds	$43,631.3	$39,521.4	($4,109.8)	-9.4%
General Fund	**$16,229.9**	**$16,646.8**	**$416.9**	**2.6%**
Other Non-Federal Funds	$9,816.7	$6,203.8	($3,612.9)	-36.8%

Note: Totals may not add due to rounding.

May 2014 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:

Medical Care Services	FY 2013-14 Appropriation	May 2014 Estimate	Change Amount	Change Percent
Total Funds	$65,196.9	$58,665.0	($6,531.9)	-10.0%
Federal Funds	$39,373.7	$36,862.1	($2,511.6)	-6.4%
General Fund	**$15,076.4**	**$15,627.0**	**$550.6**	**3.7%**
Other Non-Federal Funds	$10,746.8	$6,175.9	($4,570.9)	-42.5%

County Administration	FY 2013-14 Appropriation	May 2014 Estimate	Change Amount	Change Percent
Total Funds	$3,980.3	$3,282.3	($698.0)	-17.5%
Federal Funds	$3,071.2	$2,376.1	($695.1)	-22.6%
General Fund	**$894.8**	**$878.4**	**($16.4)**	**-1.8%**
Other Non-Federal Funds	$14.3	$27.8	$13.5	94.4%

Fiscal Intermediary	FY 2013-14 Appropriation	May 2014 Estimate	Change Amount	Change Percent
Total Funds	$353.2	$424.7	$71.5	20.2%
Federal Funds	$230.6	$283.2	$52.6	22.8%
General Fund	**$122.5**	**$141.4**	**$18.9**	**15.4%**
Other Non-Federal Funds	$0.1	$0.1	$0.0	0.0%

Total Expenditures	FY 2013-14 Appropriation	May 2014 Estimate	Change Amount	Change Percent
Total Funds	$69,530.4	$62,372.1	($7,158.3)	-10.3%
Federal Funds	$42,675.4	$39,521.4	($3,154.0)	-7.4%
General Fund	**$16,093.7**	**$16,646.8**	**$553.1**	**3.4%**
Other Non-Federal Funds	$10,761.2	$6,203.8	($4,557.4)	-42.4%

Note: Totals may not add due to rounding.

The May 2014 Estimate for FY 2013-14 is $416.9 million General Fund greater than the November 2013 Estimate.

(In Millions, May Not Add Due to Rounding)

November 2013 General Fund	$16,229.9
May 2014 General Fund	$16,646.8
General Fund Change	**$416.9**

This change from the November 2013 Estimate is explained as follows:

Medical Care Services	$332.8
County/Other Administration	$84.1
Fiscal Intermediary	$0.0

The following paragraphs briefly describe the major changes:

ACA Expansion (PCs 18, 21)

The ACA Optional and Mandatory Expansions increased over the November Estimate by $82.1 million GF in FY 2013-14 and $309.3 million GF in FY 2014-15. This is primarily driven by large increases in caseload compared to the November Estimate. The June 2014 combined caseload is estimated to be 95% higher than in November while the June 2015 caseload is now estimated to be 83% higher. The increase reflects large pending caseloads at CalHEERS.

Other ACA Items (PCs 25, 26, 28, 206, 210, 217)

The impact of a variety of other ACA items is an increase of $63.9 million in FY 2013-14 and $37.1 million in FY 2014-15. These items include Hospital Presumptive Eligibility, Delay of Redeterminations, Newly Qualified Aliens under ACA, Express Lane Enrollment, Pregnancy Only, and ACA MAGI savings. Significant changes include slower phase-in for Hospital PE; extension of the delayed redeterminations from March to June along with the inclusion of non-MAGI cases; increased response rate in Express Lane enrollment; and addition of the ACA MAGI savings estimate.

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

The CCI estimate reflects a decreased GF savings in FY 2013-14 of $23.5 million. In FY 2014-15 the previously estimated cost is now a savings, accounting for an overall GF decrease of $134.5 million. The CCI estimate reflects a revised implementation schedule and treatment of certain Medicare Advantage/D-SNP eligibles. There are now preliminary capitation rates for most dual eligibles.

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

The Estimate increases the three major types of managed care plans costs by $582.3 million GF in FY 2013-14 and $834.8 million GF in FY 2014-15. A rate adjustment is included in these PCs in the May Estimate but was not included in them in the November Estimate. Also, the COHS model PC includes rural expansion counties. In November these were separately budgeted. The Optional Targeted Low-Income Children's Program (OTLICP) eligibles including former Healthy Families Program eligibles are now included in the three model PCs rather than in a separate PC.

Other Managed Care Issues (PCs 22 and 124)

The retroactive managed care rate adjustments have not been approved in time to be paid in FY 2013-14 and now will be paid in FY 2014-15. The cost of the mental health services expansion has been revised to reflect updated caseload. The net impact from these two items is a GF decrease of $162.8 million in FY 2013-14 and a GF increase of $188.5 million in FY 2014-15.

Drug Medi-Cal (PC 63)

The Residential Treatment Services policy change reflects no GF cost in FY 2013-14, a reduction of $21.0 million GF. The SPA covering the ACA expansion of DMC services starting January 1, 2014 did not include providing Residential Treatment Services to non-perinatal beneficiaries. A waiver has been submitted to add this service, with an effective date of July 1, 2014. Starting FY 2014-15, pregnant and postpartum eligibility restrictions will be lifted for Residential Treatment Services beneficiaries making this service available to an expanded population.

Drug Rebates (PCs 34, 59, 60, 61, 211)

Overall drug rebates increased by $75.0 million GF in FY 2013-14 and decreased by $77.39 million GF in FY 2014 over the November Estimate amounts. Aged and Disputed Rebates now includes managed care rebates. The Federal Drug Rebate Program includes the percentage of drug rebates that are 100% retained by the federal government due to the ACA. This special federal share was previously estimated at $112 million annually but has increased to $155 million to reflect recent rebate reports.

Dental Services (PCs 38, 125, 175)

The estimated cost of dental services, including the restoration of select adult dental benefits, increased by $25.5 million GF in FY 2013-14 and $70.3 million GF in FY 2014-15. These increases are primarily driven by increases in caseload. Updated rates have not been included in these PCs.

Provider Rate Reductions (PCs 155, 157)

AB 97 (Chapter 3, Statutes of 2011) enacted provider rate reductions. In order to ensure access to services, the Department will exempt Community-Based Adult Services providers located in San Francisco from the 10% payment reduction. In addition, due to workload issues for the Fiscal Intermediary, implementation dates of payment reductions for intermediate care facilities for the developmentally disabled and Child Health and Disability Prevention providers were delayed. These changes result in an increase of $22.6 million General Fund in FY 2013-14 and $11.4 million General Fund in FY 2014-15.

Reduction to Radiology Rates (PC 156)

SB 853 (Chapter 717, Statutes of 2010) reduced Medi-Cal rates for radiology services to 80% of Medicare rates. Due to delay in federal approval and updated data, the Estimate decreases General Fund savings by $14.3 million in FY 2013-14 and $13.8 million in FY 2014-15.

BTR – Designated State Health Programs (PCs 91, 95, 105, 106, 108)

The California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration allows the Department to claim federal financial participation using the Certified Public Expenditures (CPEs) of approved Designated State Health Programs (DSHP) and Designated Public Hospitals (DPHs) to achieve $400 million in annual General Fund savings. The federal reimbursements received from the California Children Services and Genetically Handicapped Persons Program are budgeted in the Family Health Estimate. Due to delay in using DPHs' available CPEs and a decrease in the transfer amount for the California Department of Public Health's Aids Drug Assistance Program in FY 2013-14, the Estimate assumes a decrease of General Fund savings of $84.4 million in FY 2013-14 and an increase of General Fund savings of $84.1 million in FY 2014-15.

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 delay in federal approval, $155.0 million General Fund savings are shifted from FY 2013-14 to FY 2014-15.

County Administration

The County Administration estimate increased by $93.7 million GF in FY 2013-14 and $64.8 million GF in FY 2014-15. Significant changes include Increased funding for implementation of ACA and a three-month delay in enhanced federal funding for FY 2013-14.

May 2014 Medi-Cal Estimate

Budget Year (FY 2014-15) Projected Expenditures Compared to the November 2013 Estimate

(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 November 2013 Estimate are as follows:

Medical Care Services	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$69,725.3	$86,366.8	$16,641.5	23.9%
Federal Funds	$42,776.4	$55,442.8	$12,666.4	29.6%
General Fund	**$16,123.4**	**$16,516.3**	**$392.9**	**2.4%**
Other Non-Federal Funds	$10,825.5	$14,407.7	$3,582.2	33.1%

County Administration	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$3,361.9	$3,724.4	$362.5	10.8%
Federal Funds	$2,684.1	$2,967.1	$283.0	10.5%
General Fund	**$648.9**	**$727.9**	**$79.0**	**12.2%**
Other Non-Federal Funds	$28.9	$29.4	$0.5	1.7%

Fiscal Intermediary	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$419.3	$492.9	$73.6	17.6%
Federal Funds	$292.0	$335.1	$43.1	14.8%
General Fund	**$127.2**	**$157.6**	**$30.4**	**23.9%**
Other Non-Federal Funds	$0.1	$0.2	$0.1	100.0%

Total Expenditures	Nov 2013 Estimate	May 2014 Estimate	Change	
			Amount	Percent
Total Funds	$73,506.4	$90,584.1	$17,077.6	23.2%
Federal Funds	$45,752.5	$58,745.0	$12,992.5	28.4%
General Fund	**$16,899.5**	**$17,401.8**	**$502.4**	**3.0%**
Other Non-Federal Funds	$10,854.5	$14,437.3	$3,582.8	33.0%

Note: Totals may not add due to rounding.

May 2014 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:

Medical Care Services	FY 2013-14 Estimate	FY 2014-15 Estimate	Change	
			Amount	Percent
Total Funds	$58,665.0	$86,366.8	$27,701.8	47.2%
Federal Funds	$36,862.1	$55,442.8	$18,580.7	50.4%
General Fund	**$15,627.0**	**$16,516.3**	**$889.3**	**5.7%**
Other Non-Federal Funds	$6,175.9	$14,407.7	$8,231.8	133.3%

County Administration	FY 2013-14 Estimate	FY 2014-15 Estimate	Change	
			Amount	Percent
Total Funds	$3,282.3	$3,724.4	$442.1	13.5%
Federal Funds	$2,376.1	$2,967.1	$591.0	24.9%
General Fund	**$878.4**	**$727.9**	**($150.5)**	**-17.1%**
Other Non-Federal Funds	$27.8	$29.4	$1.6	5.8%

Fiscal Intermediary	FY 2013-14 Estimate	FY 2014-15 Estimate	Change	
			Amount	Percent
Total Funds	$424.7	$492.9	$68.2	16.1%
Federal Funds	$283.2	$335.1	$51.9	18.3%
General Fund	**$141.4**	**$157.6**	**$16.2**	**11.5%**
Other Non-Federal Funds	$0.1	$0.2	$0.1	100.0%

Total Expenditures	FY 2013-14 Estimate	FY 2014-15 Estimate	Change	
			Amount	Percent
Total Funds	$62,372.1	$90,584.1	$28,212.0	45.2%
Federal Funds	$39,521.4	$58,745.0	$19,223.6	48.6%
General Fund	**$16,646.8**	**$17,401.8**	**$755.1**	**4.5%**
Other Non-Federal Funds	$6,203.8	$14,437.3	$8,233.5	132.7%

Note: Totals may not add due to rounding.

The May 2014 General Fund Estimate for FY 2014-15 is $502.4 million greater than the November 2013 Estimate.

(In Millions, May Not Add Due to Rounding)

November 2013 General Fund	$16,899.5
May 2014 General Fund	$17,401.8
General Fund Change	**$502.4**

This change from the November 2013Estimate is explained as follows:

Medical Care Services	$392.9
County/Other Administration	$79.0
Fiscal Intermediary	$30.4

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

Vision Outreach (PC 219

This new policy change includes $1.0 million General Fund in FY 2014-15 for a pilot program in Los Angeles County. Medi-Cal managed care plans would contract with certain mobile vision service providers to increase vision examinations and the provision of necessary eyeglasses for children.

Fiscal Intermediary (FI)

The Dental FI contract increased due to the addition of the Restoration of Adult Dental Benefits, resulting in an increase of $3 million GF. The Health Care Options contract increased by $25 million GF due to an increase in the base volume and costs related to the Coordinated Care Initiative and Express Lane enrollment.

General Information

This estimate is based on actual payment data through February 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, and Dental Managed Care.

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.

Inconsistency in payment data and the irregular flow of payments add to uncertainty. Provider payment reductions, injunctions, restorations and payment methodology changes add to this uncertainty as it disturbs the regular flow of the FI checkwrite payments. Currently, Medi-Cal is undergoing large changes with the expansion of managed care, Medicaid expansion, and incorporation of other programs; these changes also add to the uncertainty of the estimate. A 1% variation in total Medi-Cal Benefits expenditures would result in a $624 million TF ($166 million General Funds) change in expenditures in FY 2013-14 and $906 million TF ($174 million General Funds) in FY 2014-15.

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

TOTAL FUNDS

	Nov 2013 Estimate	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$51,851,973,000	$48,092,944,000	($3,759,029,000)
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$58,946,000	$58,946,000	$0
4260-101-0233 Prop. 99 Physician Srvcs. 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	$11,537,000	$13,750,000	$2,213,000
4260-101-3213 LTC QA Fund	$439,445,000	$439,445,000	$0
4260-102-0001/0890 Capital Debt	$97,380,000	$100,824,000	$3,444,000
4260-104-0001 NDPH Hosp Supp *	$3,531,000	$3,531,000	$0
4260-601-3096 NDPH Suppl	$4,255,000	$3,800,000	($455,000)
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	$124,301,000	$125,301,000	$1,000,000
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	$52,745,000	$46,759,000	($5,986,000)
4260-113-0001/0890 Healthy Families	$1,853,963,000	$2,470,318,000	$616,355,000
4260-113-3055 County Health Initiative Matching Fund	$0	$0	$0
4260-601-0942142 Local Trauma Centers	$50,000,000	$50,000,000	$0
4260-601-3156 MCO Tax Fund	$829,102,000	$805,025,000	($24,077,000)
4260-601-3158 Hosp. Quality Assurance Revenue	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$797,824,000	$792,218,000	($5,606,000)
4260-601-7502 Demonstration DSH Fund	$893,842,000	$863,448,000	($30,394,000)
4260-601-7503 Health Care Support Fund	$998,652,000	$806,969,000	($191,683,000)
4260-602-0309 Perinatal Insurance Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$24,552,000	$26,960,000	$2,408,000
4260-605-3167 SNF Quality & Accountability	$20,337,000	$22,745,000	$2,408,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($24,552,000)	($26,960,000)	($2,408,000)
4260-606-0834 SB 1100 DSH	$394,037,000	$456,294,000	$62,257,000
4260-607-8502 Low Income Health Program IGT	$2,383,690,000	$150,106,000	($2,233,584,000)
4260-610-0995 Reimbursements	$903,077,000	$1,003,358,000	$100,281,000
4260-610-3158 Hospital Quality Assurance Revenue	$525,000	$0	($525,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
4260-611-3158 Hospital Quality Assurance Revenue	$3,851,018,000	$2,338,415,000	($1,512,603,000)
TOTAL MEDI-CAL Benefits	**$65,641,008,000**	**$58,665,024,000**	**($6,975,984,000)**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,456,342,000	$3,141,497,000	($314,845,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$485,000	$485,000	$0
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,835,000	$2,835,000	$0
4260-113-0001/0890 Healthy Families	$116,617,000	$105,759,000	($10,858,000)
4260-117-0001/0890 HIPPA	$3,468,000	$3,940,000	$472,000
4260-601-0942285/0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,250,000	$0
4260-605-3167 SNF Quality & Accountibility Admin.	$16,030,000	$2,780,000	($13,250,000)
4260-610-0995 Reimbursements	$13,458,000	$11,801,000	($1,657,000)
TOTAL COUNTY ADMIN.	**$3,622,485,000**	**$3,282,347,000**	**($340,138,000)**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$365,790,000	$379,118,000	$13,328,000
4260-113-0001/0890 Healthy Families	$26,648,000	$24,110,000	($2,538,000)
4260-117-0001/0890 HIPAA	$21,699,000	$21,338,000	($361,000)
4260-601-0001 100% General Fund	$0	$0	$0
4260-610-0995 Reimbursements	$115,000	$119,000	$4,000
TOTAL FISCAL INTERMEDIARY	**$414,252,000**	**$424,685,000**	**$10,433,000**
GRAND TOTAL - ALL FUNDS	**$69,677,745,000**	**$62,372,056,000**	**($7,305,689,000)**

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

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

STATE FUNDS

	Nov 2013 Estimate	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$14,540,449,000	$14,662,161,000	$121,712,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$58,946,000	$58,946,000	$0
4260-101-0233 Prop. 99 Physician Srvcs. 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	$11,537,000	$13,750,000	$2,213,000
4260-101-3213 LTC QA Fund	$439,445,000	$439,445,000	$0
4260-102-0001 Capital Debt *	$48,690,000	$50,412,000	$1,722,000
4260-104-0001 NDPH Hosp Supp *	$3,531,000	$3,531,000	$0
4260-601-3096 NDPH Suppl	$4,255,000	$3,800,000	($455,000)
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	$124,301,000	$125,301,000	$1,000,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($77,360,000)	($77,360,000)	$0
4260-113-0001 Healthy Families *	$599,589,000	$806,573,000	$206,984,000
4260-113-3055 County Health Initiative Matching Fund	$0	$0	$0
4260-601-0942142 Local Trauma Centers	$50,000,000	$50,000,000	$0
4260-601-3156 MCO Tax Fund	$829,102,000	$805,025,000	($24,077,000)
4260-601-3158 Hosp. Quality Assurance Revenue	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$797,824,000	$792,218,000	($5,606,000)
4260-602-0309 Perinatal Insurance Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$24,552,000	$26,960,000	$2,408,000
4260-605-3167 SNF Quality & Accountability	$20,337,000	$22,745,000	$2,408,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($24,552,000)	($26,960,000)	($2,408,000)
4260-606-0834 SB 1100 DSH	$394,037,000	$456,294,000	$62,257,000
4260-607-8502 Low Income Health Program IGT	$2,383,690,000	$150,106,000	($2,233,584,000)
4260-610-0995 Reimbursements	$903,077,000	$1,003,358,000	$100,281,000
4260-610-3158 Hospital Quality Assurance Revenue	$525,000	$0	($525,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$0	$0
4260-611-3158 Hospital Quality Assurance Revenue	$3,851,018,000	$2,338,415,000	($1,512,603,000)
TOTAL MEDI-CAL Benefits	**$25,081,181,000**	**$21,802,908,000**	**($3,278,273,000)**
Total Benefits General Fund *	**$15,294,171,000**	**$15,626,997,000**	**$332,826,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$758,388,000	$845,268,000	$86,880,000
4260-113-0001 Healthy Families *	$35,406,000	$32,512,000	($2,894,000)
4260-117-0001 HIPAA *	$504,000	$622,000	$118,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,250,000	$0
4260-605-3167 SNF Quality & Accountibility Admin.	$2,780,000	$2,780,000	$0
4260-610-0995 Reimbursements	$13,458,000	$11,801,000	($1,657,000)
TOTAL COUNTY ADMIN.	**$823,786,000**	**$906,233,000**	**$82,447,000**
Total Co. Admin. General Fund *	**$794,298,000**	**$878,402,000**	**$84,104,000**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$128,149,000	$128,711,000	$562,000
4260-113-0001 Healthy Families *	$9,327,000	$8,439,000	($888,000)
4260-117-0001 HIPAA *	$3,935,000	$4,211,000	$276,000
4260-601-0001 100% General Fund *	$0	$0	$0
4260-610-0995 Reimbursements	$115,000	$119,000	$4,000
TOTAL FISCAL INTERMEDIARY	**$141,526,000**	**$141,480,000**	**($46,000)**
Total FI General Fund *	**$141,411,000**	**$141,361,000**	**($50,000)**
GRAND TOTAL - STATE FUNDS	**$26,046,493,000**	**$22,850,621,000**	**($3,195,872,000)**
Grand Total - General Fund*	**$16,229,880,000**	**$16,646,760,000**	**$416,880,000**

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

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

FEDERAL FUNDS

	Nov 2013 Estimate	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$37,311,524,000	$33,430,783,000	($3,880,741,000)
4260-102-0890 Capital Debt	$48,690,000	$50,412,000	$1,722,000
4260-106-0890 Money Follow Person Federal Grant	$52,745,000	$46,759,000	($5,986,000)
4260-113-0890 Healthy Families	$1,254,374,000	$1,663,745,000	$409,371,000
4260-601-7502 Demonstration DSH Fund	$893,842,000	$863,448,000	($30,394,000)
4260-601-7503 Health Care Support Fund	$998,652,000	$806,969,000	($191,683,000)
TOTAL MEDI-CAL Benefits	**$40,559,827,000**	**$36,862,116,000**	**($3,697,711,000)**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$2,697,954,000	$2,296,229,000	($401,725,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$485,000	$485,000	$0
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,835,000	$2,835,000	$0
4260-113-0890 Healthy Families	$81,211,000	$73,247,000	($7,964,000)
4260-117-0890 HIPAA	$2,964,000	$3,318,000	$354,000
4260-601-0890 Hlthcare Outreach & Medi-Cal Enroll. Ac	$13,250,000	$0	($13,250,000)
TOTAL COUNTY ADMIN.	**$2,798,699,000**	**$2,376,114,000**	**($422,585,000)**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$237,641,000	$250,407,000	$12,766,000
4260-113-0890 Healthy Families	$17,321,000	$15,671,000	($1,650,000)
4260-117-0890 HIPAA	$17,764,000	$17,127,000	($637,000)
TOTAL FISCAL INTERMEDIARY	**$272,726,000**	**$283,205,000**	**$10,479,000**
GRAND TOTAL - FEDERAL FUNDS	**$43,631,252,000**	**$39,521,435,000**	**($4,109,817,000)**

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

TOTAL FUNDS

	Total Appropriation	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$50,771,860,000	$48,092,944,000	($2,678,916,000)
4260-101-0080 CLPP Funds	$130,000	$714,000	$584,000
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$58,946,000	$58,946,000	$0
4260-101-0233 Prop. 99 Physician Srvcs. 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	$13,750,000	$2,321,000
4260-101-3213 LTC QA Fund	$436,646,000	$439,445,000	$2,799,000
4260-102-0001/0890 Capital Debt	$92,086,000	$100,824,000	$8,738,000
4260-104-0001 NDPH Hosp Supp *	$3,531,000	$3,531,000	$0
4260-601-3096 NDPH Suppl	$3,802,000	$3,800,000	($2,000)
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	$125,301,000	($3,294,000)
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	$46,759,000	$13,679,000
4260-113-0001/0890 Healthy Families	$1,761,373,000	$2,470,318,000	$708,945,000
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	$805,025,000	($44,053,000)
4260-601-3158 Hosp. Quality Assurance Revenue	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$772,646,000	$792,218,000	$19,572,000
4260-601-7502 Demonstration DSH Fund	$520,264,000	$863,448,000	$343,184,000
4260-601-7503 Health Care Support Fund	$1,163,739,000	$806,969,000	($356,770,000)
4260-602-0309 Perinatal Insurance Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$26,756,000	$26,960,000	$204,000
4260-605-3167 SNF Quality & Accountability	$20,701,000	$22,745,000	$2,044,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($26,756,000)	($26,960,000)	($204,000)
4260-606-0834 SB 1100 DSH	$662,764,000	$456,294,000	($206,470,000)
4260-607-8502 Low Income Health Program IGT	$2,104,001,000	$150,106,000	($1,953,895,000)
4260-610-0995 Reimbursements	$1,602,811,000	$1,003,358,000	($599,453,000)
4260-610-3158 Hospital Quality Assurance Revenue	$1,000,000	$0	($1,000,000)
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	$2,338,415,000	($1,765,669,000)
TOTAL MEDI-CAL Benefits	**$65,196,880,000**	**$58,665,024,000**	**($6,531,856,000)**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,866,732,000	$3,141,497,000	($725,235,000)
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	$105,759,000	$13,203,000
4260-117-0001/0890 HIPPA	$3,452,000	$3,940,000	$488,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$0	$13,250,000	$13,250,000
4260-605-3167 SNF Quality & Accountibility Admin.	$2,433,000	$2,780,000	$347,000
4260-610-0995 Reimbursements	$11,903,000	$11,801,000	($102,000)
TOTAL COUNTY ADMIN.	**$3,980,303,000**	**$3,282,347,000**	**($697,956,000)**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$325,979,000	$379,118,000	$53,139,000
4260-113-0001/0890 Healthy Families	$868,000	$24,110,000	$23,242,000
4260-117-0001/0890 HIPAA	$25,749,000	$21,338,000	($4,411,000)
4260-601-0001 100% General Fund	$500,000	$0	($500,000)
4260-610-0995 Reimbursements	$101,000	$119,000	$18,000
TOTAL FISCAL INTERMEDIARY	**$353,197,000**	**$424,685,000**	**$71,488,000**
GRAND TOTAL - ALL FUNDS	**$69,530,380,000**	**$62,372,056,000**	**($7,158,324,000)**

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

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

STATE FUNDS

	State Funds Appropriation	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$14,355,054,000	$14,662,161,000	$307,107,000
4260-101-0080 CLPP Funds	$130,000	$714,000	$584,000
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$58,946,000	$58,946,000	$0
4260-101-0233 Prop. 99 Physician Srvcs. 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	$13,750,000	$2,321,000
4260-101-3213 LTC QA Fund	$436,646,000	$439,445,000	$2,799,000
4260-102-0001 Capital Debt *	$46,043,000	$50,412,000	$4,369,000
4260-104-0001 NDPH Hosp Supp *	$3,531,000	$3,531,000	$0
4260-601-3096 NDPH Suppl	$3,802,000	$3,800,000	($2,000)
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	$125,301,000	($3,294,000)
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	$806,573,000	$238,957,000
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	$805,025,000	($44,053,000)
4260-601-3158 Hosp. Quality Assurance Revenue	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$772,646,000	$792,218,000	$19,572,000
4260-602-0309 Perinatal Insurance Fund	$0	$0	$0
4260-605-0001 SNF Quality & Accountability *	$26,756,000	$26,960,000	$204,000
4260-605-3167 SNF Quality & Accountability	$20,701,000	$22,745,000	$2,044,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($26,756,000)	($26,960,000)	($204,000)
4260-606-0834 SB 1100 DSH	$662,764,000	$456,294,000	($206,470,000)
4260-607-8502 Low Income Health Program IGT	$2,104,001,000	$150,106,000	($1,953,895,000)
4260-610-0995 Reimbursements	$1,602,811,000	$1,003,358,000	($599,453,000)
4260-610-3158 Hospital Quality Assurance Revenue	$1,000,000	$0	($1,000,000)
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	$2,338,415,000	($1,765,669,000)
TOTAL MEDI-CAL Benefits	**$25,823,191,000**	**$21,802,908,000**	**($4,020,283,000)**
Total Benefits General Fund *	**$15,076,360,000**	**$15,626,997,000**	**$550,637,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$866,567,000	$845,268,000	($21,299,000)
4260-113-0001 Healthy Families *	$27,738,000	$32,512,000	$4,774,000
4260-117-0001 HIPAA *	$500,000	$622,000	$122,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$0	$13,250,000	$13,250,000
4260-605-3167 SNF Quality & Accountibility Admin.	$2,433,000	$2,780,000	$347,000
4260-610-0995 Reimbursements	$11,903,000	$11,801,000	($102,000)
TOTAL COUNTY ADMIN.	**$909,141,000**	**$906,233,000**	**($2,908,000)**
Total Co. Admin. General Fund *	**$894,805,000**	**$878,402,000**	**($16,403,000)**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$117,382,000	$128,711,000	$11,329,000
4260-113-0001 Healthy Families *	$304,000	$8,439,000	$8,135,000
4260-117-0001 HIPAA *	$4,347,000	$4,211,000	($136,000)
4260-601-0001 100% General Fund *	$500,000	$0	($500,000)
4260-610-0995 Reimbursements	$101,000	$119,000	$18,000
TOTAL FISCAL INTERMEDIARY	**$122,634,000**	**$141,480,000**	**$18,846,000**
Total FI General Fund *	**$122,533,000**	**$141,361,000**	**$18,828,000**
GRAND TOTAL - STATE FUNDS	**$26,854,966,000**	**$22,850,621,000**	**($4,004,345,000)**
Grand Total - General Fund *	**$16,093,698,000**	**$16,646,760,000**	**$553,062,000**

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

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

FEDERAL FUNDS

	Federal Funds Appropriation	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$36,416,806,000	$33,430,783,000	($2,986,023,000)
4260-102-0890 Capital Debt	$46,043,000	$50,412,000	$4,369,000
4260-106-0890 Money Follow Person Federal Grant	$33,080,000	$46,759,000	$13,679,000
4260-113-0890 Healthy Families	$1,193,757,000	$1,663,745,000	$469,988,000
4260-601-7502 Demonstration DSH Fund	$520,264,000	$863,448,000	$343,184,000
4260-601-7503 Health Care Support Fund	$1,163,739,000	$806,969,000	($356,770,000)
TOTAL MEDI-CAL Benefits	**$39,373,689,000**	**$36,862,116,000**	**($2,511,573,000)**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,000,165,000	$2,296,229,000	($703,936,000)
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	$73,247,000	$8,429,000
4260-117-0890 HIPAA	$2,952,000	$3,318,000	$366,000
TOTAL COUNTY ADMIN.	**$3,071,162,000**	**$2,376,114,000**	**($695,048,000)**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$208,597,000	$250,407,000	$41,810,000
4260-113-0890 Healthy Families	$564,000	$15,671,000	$15,107,000
4260-117-0890 HIPAA	$21,402,000	$17,127,000	($4,275,000)
TOTAL FISCAL INTERMEDIARY	**$230,563,000**	**$283,205,000**	**$52,642,000**
GRAND TOTAL - FEDERAL FUNDS	**$42,675,414,000**	**$39,521,435,000**	**($3,153,979,000)**

Medi-Cal Funding Summary
May 2014 Estimate Compared to November 2013 Estimate
Fiscal Year 2014 - 2015

TOTAL FUNDS

	Nov 2013 Estimate	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$55,278,973,000	$67,207,774,000	$11,928,801,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$72,435,000	$74,137,000	$1,702,000
4260-101-0233 Prop. 99 Physician Srvcs. Acct.	$105,000	$105,000	$0
4260-101-0236 Prop. 99 Unallocated Account	$26,991,000	$25,289,000	($1,702,000)
4260-101-3168 Emergency Air Transportation Fund	$9,133,000	$18,750,000	$9,617,000
4260-101-3213 LTC QA Fund	$470,374,000	$470,374,000	$0
4260-102-0001/0890 Capital Debt	$90,422,000	$126,924,000	$36,502,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,901,000	$2,356,000	$455,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$121,501,000	$134,001,000	$12,500,000
4260-698-3097 Private Hosp Suppl (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follow Person Federal Grant	$25,528,000	$27,328,000	$1,800,000
4260-113-0001/0890 Healthy Families	$2,069,468,000	$3,049,290,000	$979,822,000
4260-113-3055 County Health Initiative Matching Fund	$509,000	$215,000	($294,000)
4260-601-0942142 Local Trauma Centers	$35,000,000	$35,000,000	$0
4260-601-3156 MCO Tax Fund	$1,172,397,000	$1,388,941,000	$216,544,000
4260-601-3158 Hosp. Quality Assurance Revenue	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$946,155,000	$576,312,000	($369,843,000)
4260-601-7502 Demonstration DSH Fund	$613,331,000	$577,384,000	($35,947,000)
4260-601-7503 Health Care Support Fund	$676,618,000	$801,253,000	$124,635,000
4260-602-0309 Perinatal Insurance Fund	$57,459,000	$56,396,000	($1,063,000)
4260-605-0001 SNF Quality & Accountability *	$25,161,000	$48,867,000	$23,706,000
4260-605-3167 SNF Quality & Accountability	$21,329,000	$45,034,000	$23,705,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($25,161,000)	($48,867,000)	($23,706,000)
4260-606-0834 SB 1100 DSH	$548,529,000	$617,056,000	$68,527,000
4260-607-8502 Low Income Health Program IGT	$0	$1,985,006,000	$1,985,006,000
4260-610-0995 Reimbursements	$3,233,332,000	$4,641,938,000	$1,408,606,000
4260-610-3158 Hospital Quality Assurance Revenue	$0	$553,000	$553,000
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$97,781,000	$97,781,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,253,059,000	$4,406,846,000	$153,787,000
TOTAL MEDI-CAL Benefits	**$69,725,263,000**	**$86,366,757,000**	**$16,641,494,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,216,922,000	$3,583,347,000	$366,425,000
4260-106-0890(1) Money Follow Person Fed. Grant	$648,000	$517,000	($131,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,660,000	$2,660,000	$0
4260-113-0001/0890 Healthy Families	$95,652,000	$102,221,000	$6,569,000
4260-117-0001/0890 HIPPA	$3,939,000	$6,267,000	$2,328,000
4260-601-0942285/0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$26,500,000	$13,250,000	($13,250,000)
4260-605-3167 SNF Quality & Accountibility Admin.	$2,533,000	$2,533,000	$0
4260-610-0995 Reimbursements	$13,058,000	$13,635,000	$577,000
TOTAL COUNTY ADMIN.	**$3,361,912,000**	**$3,724,430,000**	**$362,518,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$376,850,000	$456,441,000	$79,591,000
4260-113-0001/0890 Healthy Families	$19,787,000	$14,283,000	($5,504,000)
4260-117-0001/0890 HIPAA	$22,500,000	$22,006,000	($494,000)
4260-601-0001 100% General Fund	$0	$0	$0
4260-610-0995 Reimbursements	$134,000	$141,000	$7,000
TOTAL FISCAL INTERMEDIARY	**$419,271,000**	**$492,871,000**	**$73,600,000**
GRAND TOTAL - ALL FUNDS	**$73,506,446,000**	**$90,584,058,000**	**$17,077,612,000**

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

Medi-Cal Funding Summary
May 2014 Estimate Compared to November 2013 Estimate
Fiscal Year 2014 - 2015

STATE FUNDS

	Nov 2013 Estimate	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$15,296,450,000	$15,309,941,000	$13,491,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$72,435,000	$74,137,000	$1,702,000
4260-101-0233 Prop. 99 Physician Srvcs. Acct.	$105,000	$105,000	$0
4260-101-0236 Prop. 99 Unallocated Account	$26,991,000	$25,289,000	($1,702,000)
4260-101-3168 Emergency Air Transportation Fund	$9,133,000	$18,750,000	$9,617,000
4260-101-3213 LTC QA Fund	$470,374,000	$470,374,000	$0
4260-102-0001 Capital Debt *	$45,211,000	$63,462,000	$18,251,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$1,901,000	$2,356,000	$455,000
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$121,501,000	$134,001,000	$12,500,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$636,254,000	$973,767,000	$337,513,000
4260-113-3055 County Health Initiative Matching Fund	$509,000	$215,000	($294,000)
4260-601-0942142 Local Trauma Centers	$35,000,000	$35,000,000	$0
4260-601-3156 MCO Tax Fund	$1,172,397,000	$1,388,941,000	$216,544,000
4260-601-3158 Hosp. Quality Assurance Revenue	$0	$0	$0
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$946,155,000	$576,312,000	($369,843,000)
4260-602-0309 Perinatal Insurance Fund	$57,459,000	$56,396,000	($1,063,000)
4260-605-0001 SNF Quality & Accountability *	$25,161,000	$48,867,000	$23,706,000
4260-605-3167 SNF Quality & Accountability	$21,329,000	$45,034,000	$23,705,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($25,161,000)	($48,867,000)	($23,706,000)
4260-606-0834 SB 1100 DSH	$548,529,000	$617,056,000	$68,527,000
4260-607-8502 Low Income Health Program IGT	$0	$1,985,006,000	$1,985,006,000
4260-610-0995 Reimbursements	$3,233,332,000	$4,641,938,000	$1,408,606,000
4260-610-3158 Hospital Quality Assurance Revenue	$0	$553,000	$553,000
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$97,781,000	$97,781,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,253,059,000	$4,406,846,000	$153,787,000
TOTAL MEDI-CAL Benefits	**$26,948,838,000**	**$30,923,974,000**	**$3,975,136,000**
Total Benefits General Fund *	**$16,123,376,000**	**$16,516,337,000**	**$392,961,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$619,225,000	$695,687,000	$76,462,000
4260-113-0001 Healthy Families *	$29,099,000	$31,031,000	$1,932,000
4260-117-0001 HIPAA *	$622,000	$1,204,000	$582,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,250,000	$0
4260-605-3167 SNF Quality & Accountibility Admin.	$2,533,000	$2,533,000	$0
4260-610-0995 Reimbursements	$13,058,000	$13,635,000	$577,000
TOTAL COUNTY ADMIN.	**$677,787,000**	**$757,340,000**	**$79,553,000**
Total Co. Admin. General Fund *	**$648,946,000**	**$727,922,000**	**$78,976,000**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$117,531,000	$148,964,000	$31,433,000
4260-113-0001 Healthy Families *	$6,925,000	$4,999,000	($1,926,000)
4260-117-0001 HIPAA *	$2,717,000	$3,626,000	$909,000
4260-601-0001 100% General Fund *	$0	$0	$0
4260-610-0995 Reimbursements	$134,000	$141,000	$7,000
TOTAL FISCAL INTERMEDIARY	**$127,307,000**	**$157,730,000**	**$30,423,000**
Total FI General Fund *	**$127,173,000**	**$157,589,000**	**$30,416,000**
GRAND TOTAL - STATE FUNDS	**$27,753,932,000**	**$31,839,044,000**	**$4,085,112,000**
Grand Total General Fund*	**$16,899,495,000**	**$17,401,848,000**	**$502,353,000**

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

Medi-Cal Funding Summary
May 2014 Estimate Compared to November 2013 Estimate
Fiscal Year 2014 - 2015

FEDERAL FUNDS

	Nov 2013 Estimate	May 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$39,982,523,000	$51,897,833,000	$11,915,310,000
4260-102-0890 Capital Debt	$45,211,000	$63,462,000	$18,251,000
4260-106-0890 Money Follow Person Federal Grant	$25,528,000	$27,328,000	$1,800,000
4260-113-0890 Healthy Families	$1,433,214,000	$2,075,523,000	$642,309,000
4260-601-7502 Demonstration DSH Fund	$613,331,000	$577,384,000	($35,947,000)
4260-601-7503 Health Care Support Fund	$676,618,000	$801,253,000	$124,635,000
TOTAL MEDI-CAL Benefits	**$42,776,425,000**	**$55,442,783,000**	**$12,666,358,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$2,597,697,000	$2,887,660,000	$289,963,000
4260-106-0890(1) Money Follow Person Fed. Grant	$648,000	$517,000	($131,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,660,000	$2,660,000	$0
4260-113-0890 Healthy Families	$66,553,000	$71,190,000	$4,637,000
4260-117-0890 HIPAA	$3,317,000	$5,063,000	$1,746,000
4260-601-0890 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$0	($13,250,000)
TOTAL COUNTY ADMIN.	**$2,684,125,000**	**$2,967,090,000**	**$282,965,000**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$259,319,000	$307,477,000	$48,158,000
4260-113-0890 Healthy Families	$12,862,000	$9,284,000	($3,578,000)
4260-117-0890 HIPAA	$19,783,000	$18,380,000	($1,403,000)
TOTAL FISCAL INTERMEDIARY	**$291,964,000**	**$335,141,000**	**$43,177,000**
GRAND TOTAL - FEDERAL FUNDS	**$45,752,514,000**	**$58,745,014,000**	**$12,992,500,000**

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

TOTAL FUNDS

	FY 2013-14 Estimate	FY 2014-15 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$48,092,944,000	$67,207,774,000	$19,114,830,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$58,946,000	$74,137,000	$15,191,000
4260-101-0233 Prop. 99 Physician Srvcs. Acct.	$105,000	$105,000	$0
4260-101-0236 Prop. 99 Unallocated Account	$23,540,000	$25,289,000	$1,749,000
4260-101-3168 Emergency Air Transportation Fund	$13,750,000	$18,750,000	$5,000,000
4260-101-3213 LTC QA Fund	$439,445,000	$470,374,000	$30,929,000
4260-102-0001/0890 Capital Debt	$100,824,000	$126,924,000	$26,100,000
4260-104-0001 NDPH Hosp Supp *	$3,531,000	$1,900,000	($1,631,000)
4260-601-3096 NDPH Suppl	$3,800,000	$2,356,000	($1,444,000)
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	$125,301,000	$134,001,000	$8,700,000
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	$46,759,000	$27,328,000	($19,431,000)
4260-113-0001/0890 Healthy Families	$2,470,318,000	$3,049,290,000	$578,972,000
4260-113-3055 County Health Initiative Matching Fund	$0	$215,000	$215,000
4260-601-0942142 Local Trauma Centers	$50,000,000	$35,000,000	($15,000,000)
4260-601-3156 MCO Tax Fund	$805,025,000	$1,388,941,000	$583,916,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$792,218,000	$576,312,000	($215,906,000)
4260-601-7502 Demonstration DSH Fund	$863,448,000	$577,384,000	($286,064,000)
4260-601-7503 Health Care Support Fund	$806,969,000	$801,253,000	($5,716,000)
4260-602-0309 Perinatal Insurance Fund	$0	$56,396,000	$56,396,000
4260-605-0001 SNF Quality & Accountability *	$26,960,000	$48,867,000	$21,907,000
4260-605-3167 SNF Quality & Accountability	$22,745,000	$45,034,000	$22,289,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($26,960,000)	($48,867,000)	($21,907,000)
4260-606-0834 SB 1100 DSH	$456,294,000	$617,056,000	$160,762,000
4260-607-8502 Low Income Health Program IGT	$150,106,000	$1,985,006,000	$1,834,900,000
4260-610-0995 Reimbursements	$1,003,358,000	$4,641,938,000	$3,638,580,000
4260-610-3158 Hospital Quality Assurance Revenue	$0	$553,000	$553,000
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$97,781,000	$97,781,000
4260-611-3158 Hospital Quality Assurance Revenue	$2,338,415,000	$4,406,846,000	$2,068,431,000
TOTAL MEDI-CAL Benefits	**$58,665,024,000**	**$86,366,757,000**	**$27,701,733,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,141,497,000	$3,583,347,000	$441,850,000
4260-106-0890(1) Money Follow Person Fed. Grant	$485,000	$517,000	$32,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,835,000	$2,660,000	($175,000)
4260-113-0001/0890 Healthy Families	$105,759,000	$102,221,000	($3,538,000)
4260-117-0001/0890 HIPPA	$3,940,000	$6,267,000	$2,327,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,250,000	$0
4260-605-3167 SNF Quality & Accountibility Admin.	$2,780,000	$2,533,000	($247,000)
4260-610-0995 Reimbursements	$11,801,000	$13,635,000	$1,834,000
TOTAL COUNTY ADMIN.	**$3,282,347,000**	**$3,724,430,000**	**$442,083,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$379,118,000	$456,441,000	$77,323,000
4260-113-0001/0890 Healthy Families	$24,110,000	$14,283,000	($9,827,000)
4260-117-0001/0890 HIPAA	$21,338,000	$22,006,000	$668,000
4260-610-0995 Reimbursements	$119,000	$141,000	$22,000
TOTAL FISCAL INTERMEDIARY	**$424,685,000**	**$492,871,000**	**$68,186,000**
GRAND TOTAL - ALL FUNDS	**$62,372,056,000**	**$90,584,058,000**	**$28,212,002,000**

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

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

STATE FUNDS

	FY 2013-14 Estimate	FY 2014-15 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$14,662,161,000	$15,309,941,000	$647,780,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop. 99 Hospital Srvcs. Acct.	$58,946,000	$74,137,000	$15,191,000
4260-101-0233 Prop. 99 Physician Srvcs. Acct.	$105,000	$105,000	$0
4260-101-0236 Prop. 99 Unallocated Account	$23,540,000	$25,289,000	$1,749,000
4260-101-3168 Emergency Air Transportation Fund	$13,750,000	$18,750,000	$5,000,000
4260-101-3213 LTC QA Fund	$439,445,000	$470,374,000	$30,929,000
4260-102-0001 Capital Debt *	$50,412,000	$63,462,000	$13,050,000
4260-104-0001 NDPH Hosp Supp *	$3,531,000	$1,900,000	($1,631,000)
4260-601-3096 NDPH Suppl	$3,800,000	$2,356,000	($1,444,000)
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	$125,301,000	$134,001,000	$8,700,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($77,360,000)	($118,400,000)	($41,040,000)
4260-113-0001 Healthy Families *	$806,573,000	$973,767,000	$167,194,000
4260-113-3055 County Health Initiative Matching Fund	$0	$215,000	$215,000
4260-601-0942142 Local Trauma Centers	$50,000,000	$35,000,000	($15,000,000)
4260-601-3156 MCO Tax Fund	$805,025,000	$1,388,941,000	$583,916,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$792,218,000	$576,312,000	($215,906,000)
4260-602-0309 Perinatal Insurance Fund	$0	$56,396,000	$56,396,000
4260-605-0001 SNF Quality & Accountability *	$26,960,000	$48,867,000	$21,907,000
4260-605-3167 SNF Quality & Accountability	$22,745,000	$45,034,000	$22,289,000
4260-698-3167 SNF Quality & Acct. (Less Funded by GF)	($26,960,000)	($48,867,000)	($21,907,000)
4260-606-0834 SB 1100 DSH	$456,294,000	$617,056,000	$160,762,000
4260-607-8502 Low Income Health Program IGT	$150,106,000	$1,985,006,000	$1,834,900,000
4260-610-0995 Reimbursements	$1,003,358,000	$4,641,938,000	$3,638,580,000
4260-610-3158 Hospital Quality Assurance Revenue	$0	$553,000	$553,000
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$97,781,000	$97,781,000
4260-611-3158 Hospital Quality Assurance Revenue	$2,338,415,000	$4,406,846,000	$2,068,431,000
TOTAL MEDI-CAL Benefits	**$21,802,908,000**	**$30,923,974,000**	**$9,121,066,000**
Total Benefits General Fund *	**$15,626,997,000**	**$16,516,337,000**	**$889,340,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$845,268,000	$695,687,000	($149,581,000)
4260-113-0001 Healthy Families *	$32,512,000	$31,031,000	($1,481,000)
4260-117-0001 HIPAA *	$622,000	$1,204,000	$582,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,250,000	$0
4260-605-3167 SNF Quality & Accountibility Admin.	$2,780,000	$2,533,000	($247,000)
4260-610-0995 Reimbursements	$11,801,000	$13,635,000	$1,834,000
TOTAL COUNTY ADMIN.	**$906,233,000**	**$757,340,000**	**($148,893,000)**
Total Co. Admin. General Fund *	**$878,402,000**	**$727,922,000**	**($150,480,000)**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$128,711,000	$148,964,000	$20,253,000
4260-113-0001 Healthy Families *	$8,439,000	$4,999,000	($3,440,000)
4260-117-0001 HIPAA *	$4,211,000	$3,626,000	($585,000)
4260-601-0001 100% General Fund *	$0	$0	$0
4260-610-0995 Reimbursements	$119,000	$141,000	$22,000
TOTAL FISCAL INTERMEDIARY	**$141,480,000**	**$157,730,000**	**$16,250,000**
Total FI General Fund *	**$141,361,000**	**$157,589,000**	**$16,228,000**
GRAND TOTAL - STATE FUNDS	**$22,850,621,000**	**$31,839,044,000**	**$8,988,423,000**
Grand Total General Fund *	**$16,646,760,000**	**$17,401,848,000**	**$755,088,000**

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

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

FEDERAL FUNDS

	FY 2013-14 Estimate	FY 2014-15 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$33,430,783,000	$51,897,833,000	$18,467,050,000
4260-102-0890 Capital Debt	$50,412,000	$63,462,000	$13,050,000
4260-106-0890 Money Follow Person Federal Grant	$46,759,000	$27,328,000	($19,431,000)
4260-113-0890 Healthy Families	$1,663,745,000	$2,075,523,000	$411,778,000
4260-601-7502 Demonstration DSH Fund	$863,448,000	$577,384,000	($286,064,000)
4260-601-7503 Health Care Support Fund	$806,969,000	$801,253,000	($5,716,000)
TOTAL MEDI-CAL Benefits	**$36,862,116,000**	**$55,442,783,000**	**$18,580,667,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$2,296,229,000	$2,887,660,000	$591,431,000
4260-106-0890(1) Money Follow Person Fed. Grant	$485,000	$517,000	$32,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,835,000	$2,660,000	($175,000)
4260-113-0890 Healthy Families	$73,247,000	$71,190,000	($2,057,000)
4260-117-0890 HIPAA	$3,318,000	$5,063,000	$1,745,000
TOTAL COUNTY ADMIN.	**$2,376,114,000**	**$2,967,090,000**	**$590,976,000**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$250,407,000	$307,477,000	$57,070,000
4260-113-0890 Healthy Families	$15,671,000	$9,284,000	($6,387,000)
4260-117-0890 HIPAA	$17,127,000	$18,380,000	$1,253,000
TOTAL FISCAL INTERMEDIARY	**$283,205,000**	**$335,141,000**	**$51,936,000**
GRAND TOTAL - FEDERAL FUNDS	**$39,521,435,000**	**$58,745,014,000**	**$19,223,579,000**

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2013-14

	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
I. BASE ESTIMATES			
A. C/Y FFS BASE	$15,819,329,510	$7,909,664,760	$7,909,664,760
B. C/Y BASE POLICY CHANGES	$24,517,429,990	$14,592,043,300	$9,925,386,700
C. BASE ADJUSTMENTS	-$81,731,000	-$92,541,450	$10,810,450
D. ADJUSTED BASE	$40,255,028,510	$22,409,166,600	$17,845,861,900
II. REGULAR POLICY CHANGES			
A. ELIGIBILITY	$778,534,740	$585,030,520	$193,504,220
B. AFFORDABLE CARE ACT	$5,493,376,040	$5,387,473,980	$105,902,060
C. BENEFITS	$458,341,570	$509,055,690	-$50,714,120
D. PHARMACY	-$2,077,128,980	-$1,120,124,540	-$957,004,440
E. DRUG MEDI-CAL	$3,036,000	$3,036,000	$0
F. MENTAL HEALTH	$185,089,000	$144,108,000	$40,981,000
G. WAIVER--MH/UCD & BTR	$5,896,449,990	$4,740,990,500	$1,155,459,500
H. MANAGED CARE	$2,767,415,000	$1,457,040,450	$1,310,374,550
I. PROVIDER RATES	$48,884,990	$24,442,500	$24,442,500
J. SUPPLEMENTAL PMNTS.	$4,519,242,000	$2,442,294,000	$2,076,948,000
K. OTHER	$336,753,000	$279,602,000	$57,151,000
L. TOTAL CHANGES	$18,409,993,360	$14,452,949,090	$3,957,044,260
III. TOTAL MEDI-CAL ESTIMATE	**$58,665,021,860**	**$36,862,115,700**	**$21,802,906,170**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	ELIGIBILITY			
2	FAMILY PACT PROGRAM	$576,793,000	$432,325,000	$144,468,000
3	BREAST AND CERVICAL CANCER TREATMENT	$149,256,000	$83,359,900	$65,896,100
4	AIM LINKED INFANTS 250-300% FPL	$31,629,000	$20,558,850	$11,070,150
5	MEDI-CAL ADULT INMATE PROGRAMS	$14,092,000	$14,092,000	$0
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM/	$4,518,000	$4,518,000	$0
8	REFUGEES	$5,878,000	$0	$5,878,000
11	NEW QUALIFIED IMMIGRANTS	$0	-$62,996,000	$62,996,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	$86,060,700	-$86,060,700
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$8,927,700	-$8,927,700
14	INCARCERATION VERIFICATION PROGRAM	-$97,670	-$48,830	-$48,830
15	PARIS-FEDERAL	-$955,910	-$477,960	-$477,960
16	PARIS-VETERANS	-$1,275,610	-$637,810	-$637,810
17	PARIS-INTERSTATE	-$1,302,070	-$651,030	-$651,030
	ELIGIBILITY SUBTOTAL	**$778,534,740**	**$585,030,520**	**$193,504,220**
	AFFORDABLE CARE ACT			
18	ACA OPTIONAL EXPANSION	$2,857,646,000	$2,855,878,000	$1,768,000
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	$1,629,619,590	$1,600,971,680	$28,647,910
20	COMMUNITY FIRST CHOICE OPTION	$244,263,000	$244,263,000	$0
21	ACA MANDATORY EXPANSION	$419,928,000	$226,513,950	$193,414,050
22	MENTAL HEALTH SERVICES EXPANSION	$86,512,000	$54,829,350	$31,682,650
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COS	$33,935,000	$33,935,000	$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$10,390,000	$8,187,600	$2,202,400
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$14,493,000	$9,239,000	$5,254,000
27	USPSTF GRADE A AND B RECOMMENDATIONS	$11,576,510	$7,327,780	$4,248,730
28	ACA DELAY OF REDETERMINATIONS	$150,904,000	$80,324,450	$70,579,550
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	-$115,000	$115,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$45,932,000	-$45,932,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-$2,060	-$1,030	-$1,030
34	MANAGED CARE DRUG REBATES	-$379,500,000	-$189,750,000	-$189,750,000
206	ACA EXPRESS LANE ENROLLMENT	$413,611,000	$407,635,200	$5,975,800
217	ACA MAGI SAVINGS	$0	$2,303,000	-$2,303,000
	AFFORDABLE CARE ACT SUBTOTAL	**$5,493,376,040**	**$5,387,473,980**	**$105,902,060**
	BENEFITS			
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$182,932,000	$182,932,000	$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$144,983,000	$144,983,000	$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$45,621,000	$44,143,000	$1,478,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFIT	$9,121,000	$5,948,000	$3,173,000
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$40,464,000	$20,232,000	$20,232,000
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILC	$34,320,000	$17,160,000	$17,160,000
41	YOUTH REGIONAL TREATMENT CENTERS	$3,910,000	$3,134,000	$776,000

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
	BENEFITS			
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCF	$192,190	$96,090	$96,090
43	CCT FUND TRANSFER TO CDSS AND CDDS	$2,477,000	$2,477,000	$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$270,000
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$226,000	$226,000	$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$139,000	$139,000	$0
49	SCHIP FUNDING FOR PRENATAL CARE	$0	$89,107,200	-$89,107,200
51	WOMEN'S HEALTH SERVICES	-$1,445,740	-$97,830	-$1,347,910
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$14,073,000	-$7,036,500	-$7,036,500
66	VOLUNTARY INPATIENT DETOXIFICATION	$8,935,130	$5,342,730	$3,592,400
	BENEFITS SUBTOTAL	**$458,341,570**	**$509,055,690**	**-$50,714,120**
	PHARMACY			
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	$3,383,020	$1,691,510	$1,691,510
54	NON FFP DRUGS	$0	-$2,044,500	$2,044,500
55	BCCTP DRUG REBATES	-$15,389,000	-$10,002,850	-$5,386,150
56	MEDICAL SUPPLY REBATES	-$24,428,000	-$12,214,000	-$12,214,000
57	FAMILY PACT DRUG REBATES	-$78,108,000	-$68,107,200	-$10,000,800
58	LITIGATION SETTLEMENTS	-$88,253,000	$0	-$88,253,000
59	AGED AND DISPUTED DRUG REBATES	-$286,000,000	-$143,026,400	-$142,973,600
60	STATE SUPPLEMENTAL DRUG REBATES	-$209,567,000	-$106,718,300	-$102,848,700
61	FEDERAL DRUG REBATE PROGRAM	-$1,378,767,000	-$779,702,800	-$599,064,200
	PHARMACY SUBTOTAL	**-$2,077,128,980**	**-$1,120,124,540**	**-$957,004,440**
	DRUG MEDI-CAL			
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$3,036,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$3,036,000**	**$3,036,000**	**$0**
	MENTAL HEALTH			
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	$64,187,000	$64,187,000	$0
72	ELIMINATION OF STATE MAXIMUM RATES	$67,962,000	$67,962,000	$0
73	TRANSITION OF HFP - SMH SERVICES	$29,886,000	$29,886,000	$0
74	KATIE A. V. DIANA BONTA	$29,293,000	$29,293,000	$0
75	HEALTHY FAMILIES - SED	$18,769,000	$18,769,000	$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	$12,400,000	$12,400,000	$0
77	OVER ONE-YEAR CLAIMS	$3,353,000	$3,353,000	$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	$2,270,000	$2,270,000	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAY	$0	-$7,204,000	$7,204,000
80	IMD ANCILLARY SERVICES	$0	-$6,000,000	$6,000,000
81	CHART REVIEW	-$1,271,000	-$1,271,000	$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-$41,760,000	-$69,537,000	$27,777,000
	MENTAL HEALTH SUBTOTAL	**$185,089,000**	**$144,108,000**	**$40,981,000**
	WAIVER--MH/UCD & BTR			

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
	WAIVER--MH/UCD & BTR			
84	BTR - LIHP - MCE	$1,039,826,000	$912,796,500	$127,029,500
85	MH/UCD & BTR—DSH PAYMENT	$1,655,852,000	$1,259,650,000	$396,202,000
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	$1,474,435,000	$737,217,500	$737,217,500
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEM	$608,376,000	$304,188,000	$304,188,000
88	BTR—SAFETY NET CARE POOL	$317,250,000	$317,250,000	$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	$250,602,000	$125,301,000	$125,301,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$134,376,000	$111,300,000	$23,076,000
91	MH/UCD & BTR—CCS AND GHPP	$134,565,000	$134,565,000	$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	$19,933,000	$7,838,000	$12,095,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$84,400,000	$84,400,000	$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	$8,315,000	$255,085,000	-$246,770,000
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INI	$53,642,000	$53,642,000	$0
98	BTR—INCREASE SAFETY NET CARE POOL	$24,250,000	$24,250,000	$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 HE	$3,786,000	$3,786,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$9,500,000	$9,500,000	$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$7,600,000	$3,800,000	$3,800,000
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	$365,021,500	-$365,021,500
108	BTR—INCREASE DESIGNATED STATE HEALTH PROG	$0	$24,250,000	-$24,250,000
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	-$24,503,000	$24,503,000
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOV	-$48,500,000	-$48,500,000	$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLO	-$19,572,010	-$9,786,010	-$9,786,000
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,896,449,990**	**$4,740,990,500**	**$1,155,459,500**
	MANAGED CARE			
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$798,599,000	$467,404,000	$331,195,000
118	MANAGED CARE RATE RANGE IGTS	$739,514,000	$395,828,000	$343,686,000
119	CCI-MANAGED CARE PAYMENTS	$98,877,000	$49,438,500	$49,438,500
120	MANAGED CARE PUBLIC HOSPITAL IGTS	$783,992,000	$391,996,000	$391,996,000
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION	$371,327,000	$185,663,500	$185,663,500
123	CCI-TRANSFER OF IHSS COSTS TO CDSS	$39,821,000	$0	$39,821,000
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	$1,079,000	$539,500	$539,500
128	INCREASE IN CAPITATION RATES FOR GROSS PREM	$8,236,000	$4,185,950	$4,050,050
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

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
	MANAGED CARE			
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
143	CCI-SAVINGS AND DEFERRAL	-$76,030,000	-$38,015,000	-$38,015,000
	MANAGED CARE SUBTOTAL	**$2,767,415,000**	**$1,457,040,450**	**$1,310,374,550**
	PROVIDER RATES			
24	AB 1629 ADD-ONS	$3,138,740	$1,569,370	$1,569,370
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	$169,096,960	$84,548,480	$84,548,480
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$5,078,260	$2,539,130	$2,539,130
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	$45,489,000	$22,744,500	$22,744,500
147	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$22,000,000	$11,000,000	$11,000,000
148	LTC RATE ADJUSTMENT	$7,708,960	$3,854,480	$3,854,480
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$7,130,270	$3,565,140	$3,565,140
150	HOSPICE RATE INCREASES	$1,842,930	$921,460	$921,460
151	LONG TERM CARE QUALITY ASSURANCE FUND EXP	$0	$0	$0
152	NON-AB 1629 LTC RATE FREEZE	-$15,390	-$7,690	-$7,690
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$1,402,580	-$701,290	-$701,290
157	10% PROVIDER PAYMENT REDUCTION	-$211,182,160	-$105,591,080	-$105,591,080
	PROVIDER RATES SUBTOTAL	**$48,884,990**	**$24,442,500**	**$24,442,500**
	SUPPLEMENTAL PMNTS.			
158	HOSPITAL QAF - HOSPITAL PAYMENTS	$3,767,106,000	$1,872,941,000	$1,894,165,000
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$100,000,000	$100,000,000	$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$172,138,000	$172,138,000	$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	$135,742,000	$67,871,000	$67,871,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	$89,899,000	$89,899,000	$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	$120,632,000	$70,220,000	$50,412,000
166	FFP FOR LOCAL TRAUMA CENTERS	$100,000,000	$50,000,000	$50,000,000
167	IGT PAYMENTS FOR HOSPITAL SERVICES	$11,000,000	$5,500,000	$5,500,000
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$5,000,000
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$4,000,000
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEI	$4,725,000	$4,725,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$4,519,242,000**	**$2,442,294,000**	**$2,076,948,000**
	OTHER			
177	ARRA HITECH - PROVIDER PAYMENTS	$315,564,000	$315,564,000	$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$120,670,000	$120,670,000	$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMEI	$72,905,000	$36,452,500	$36,452,500
184	CDDS DENTAL SERVICES	$11,972,000	$0	$11,972,000
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDI	$20,565,000	$11,825,000	$8,740,000

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
	OTHER			
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$3,918,000	$2,743,000	$1,175,000
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
194	CLPP FUND	$0	$0	$0
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0
197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0
201	IHSS REDUCTION IN SERVICE HOURS	-$218,342,000	-$218,342,000	$0
	OTHER SUBTOTAL	**$336,753,000**	**$279,602,000**	**$57,151,000**
	GRAND TOTAL	**$18,409,993,360**	**$14,452,949,090**	**$3,957,044,270**

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
PROFESSIONAL	$5,558,911,710	$3,301,399,580	$2,257,512,130
PHYSICIANS	$1,335,191,310	$891,298,820	$443,892,490
OTHER MEDICAL	$2,974,871,250	$1,685,061,710	$1,289,809,550
COUNTY OUTPATIENT	$133,515,020	$105,302,270	$28,212,750
COMMUNITY OUTPATIENT	$1,115,334,130	$619,736,790	$495,597,340
PHARMACY	$871,818,940	$446,967,210	$424,851,730
HOSPITAL INPATIENT	$10,057,720,010	$6,308,388,400	$3,749,331,610
COUNTY INPATIENT	$2,163,420,760	$1,790,870,290	$372,550,470
COMMUNITY INPATIENT	$7,894,299,260	$4,517,518,120	$3,376,781,140
LONG TERM CARE	$4,977,840,970	$2,568,600,520	$2,409,240,450
NURSING FACILITIES	$4,585,171,550	$2,367,476,980	$2,217,694,580
ICF-DD	$392,669,410	$201,123,540	$191,545,870
OTHER SERVICES	$1,160,267,380	$643,034,970	$517,232,410
MEDICAL TRANSPORTATION	$260,297,240	$182,521,310	$77,775,940
OTHER SERVICES	$645,243,080	$327,826,540	$317,416,540
HOME HEALTH	$254,727,050	$132,687,120	$122,039,940
TOTAL FEE-FOR-SERVICE	**$22,626,559,010**	**$13,268,390,670**	**$9,358,168,330**
MANAGED CARE	$22,188,338,980	$13,347,027,970	$8,841,311,010
TWO PLAN MODEL	$13,414,476,690	$8,178,702,190	$5,235,774,500
COUNTY ORGANIZED HEALTH SYSTEMS	$6,095,838,250	$3,587,694,940	$2,508,143,310
GEOGRAPHIC MANAGED CARE	$2,194,553,170	$1,334,290,890	$860,262,280
PHP & OTHER MANAG. CARE	$483,470,870	$246,339,940	$237,130,920
DENTAL	$553,127,750	$294,235,030	$258,892,720
MENTAL HEALTH	$1,668,432,240	$1,633,084,380	$35,347,850
AUDITS/ LAWSUITS	-$75,434,780	$1,288,040	-$76,722,820
EPSDT SCREENS	$37,965,360	$20,280,880	$17,684,480
MEDICARE PAYMENTS	$3,967,162,000	$1,163,665,000	$2,803,497,000
STATE HOSP./DEVELOPMENTAL CNTRS.	$266,006,860	$265,997,830	$9,030
MISC. SERVICES	$7,745,799,460	$7,023,567,890	$722,231,570
RECOVERIES	-$312,935,000	-$155,422,000	-$157,513,000
GRAND TOTAL MEDI-CAL	**$58,665,021,860**	**$36,862,115,700**	**$21,802,906,170**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2013-14

SERVICE CATEGORY	2013-14 APPROPRIATION	MAY 2014 EST. FOR 2013-14	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,211,252,790	$5,558,911,710	-$652,341,090	-10.50
PHYSICIANS	$1,503,439,280	$1,335,191,310	-$168,247,970	-11.19
OTHER MEDICAL	$3,128,204,740	$2,974,871,250	-$153,333,490	-4.90
COUNTY OUTPATIENT	$56,860,330	$133,515,020	$76,654,690	134.81
COMMUNITY OUTPATIENT	$1,522,748,450	$1,115,334,130	-$407,414,310	-26.76
PHARMACY	$339,789,840	$871,818,940	$532,029,100	156.58
HOSPITAL INPATIENT	$11,421,243,700	$10,057,720,010	-$1,363,523,690	-11.94
COUNTY INPATIENT	$2,769,079,950	$2,163,420,760	-$605,659,200	-21.87
COMMUNITY INPATIENT	$8,652,163,750	$7,894,299,260	-$757,864,490	-8.76
LONG TERM CARE	$4,658,999,010	$4,977,840,970	$318,841,960	6.84
NURSING FACILITIES	$4,314,190,850	$4,585,171,550	$270,980,710	6.28
ICF-DD	$344,808,160	$392,669,410	$47,861,250	13.88
OTHER SERVICES	$1,099,974,840	$1,160,267,380	$60,292,530	5.48
MEDICAL TRANSPORTATION	$308,273,930	$260,297,240	-$47,976,690	-15.56
OTHER SERVICES	$572,236,050	$645,243,080	$73,007,030	12.76
HOME HEALTH	$219,464,870	$254,727,050	$35,262,190	16.07
TOTAL FEE-FOR-SERVICE	**$23,731,260,190**	**$22,626,559,010**	**-$1,104,701,180**	**-4.66**
MANAGED CARE	$22,048,885,100	$22,188,338,980	$139,453,880	0.63
TWO PLAN MODEL	$13,672,939,190	$13,414,476,690	-$258,462,500	-1.89
COUNTY ORGANIZED HEALTH SYSTEMS	$5,861,662,600	$6,095,838,250	$234,175,650	4.00
GEOGRAPHIC MANAGED CARE	$2,169,581,330	$2,194,553,170	$24,971,850	1.15
PHP & OTHER MANAG. CARE	$344,701,980	$483,470,870	$138,768,890	40.26
DENTAL	$622,285,160	$553,127,750	-$69,157,410	-11.11
MENTAL HEALTH	$2,988,603,500	$1,668,432,240	-$1,320,171,260	-44.17
AUDITS/ LAWSUITS	$10,174,220	-$75,434,780	-$85,609,000	-841.43
EPSDT SCREENS	$39,457,540	$37,965,360	-$1,492,180	-3.78
MEDICARE PAYMENTS	$4,044,466,000	$3,967,162,000	-$77,304,000	-1.91
STATE HOSP./DEVELOPMENTAL CNTRS.	$242,082,830	$266,006,860	$23,924,020	9.88
MISC. SERVICES	$11,723,140,260	$7,745,799,460	-$3,977,340,800	-33.93
RECOVERIES	-$253,476,400	-$312,935,000	-$59,458,600	23.46
GRAND TOTAL MEDI-CAL	**$65,196,878,390**	**$58,665,021,860**	**-$6,531,856,530**	**-10.02**
STATE FUNDS	**$25,823,189,190**	**$21,802,906,170**	**-$4,020,283,020**	**-15.57**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

SERVICE CATEGORY	NOV. 2013 EST. FOR 2013-14	MAY 2014 EST. FOR 2013-14	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,315,862,270	$5,558,911,710	-$756,950,560	-11.98
PHYSICIANS	$1,405,588,020	$1,335,191,310	-$70,396,710	-5.01
OTHER MEDICAL	$3,441,882,160	$2,974,871,250	-$467,010,910	-13.57
COUNTY OUTPATIENT	$142,407,890	$133,515,020	-$8,892,880	-6.24
COMMUNITY OUTPATIENT	$1,325,984,200	$1,115,334,130	-$210,650,070	-15.89
PHARMACY	$995,111,040	$871,818,940	-$123,292,100	-12.39
HOSPITAL INPATIENT	$10,263,884,270	$10,057,720,010	-$206,164,260	-2.01
COUNTY INPATIENT	$2,094,292,860	$2,163,420,760	$69,127,900	3.30
COMMUNITY INPATIENT	$8,169,591,420	$7,894,299,260	-$275,292,160	-3.37
LONG TERM CARE	$4,977,079,390	$4,977,840,970	$761,570	0.02
NURSING FACILITIES	$4,592,061,550	$4,585,171,550	-$6,890,000	-0.15
ICF-DD	$385,017,840	$392,669,410	$7,651,570	1.99
OTHER SERVICES	$1,191,783,270	$1,160,267,380	-$31,515,890	-2.64
MEDICAL TRANSPORTATION	$353,294,870	$260,297,240	-$92,997,630	-26.32
OTHER SERVICES	$589,510,840	$645,243,080	$55,732,250	9.45
HOME HEALTH	$248,977,570	$254,727,050	$5,749,490	2.31
TOTAL FEE-FOR-SERVICE	**$23,743,720,250**	**$22,626,559,010**	**-$1,117,161,240**	**-4.71**
MANAGED CARE	$23,231,037,950	$22,188,338,980	-$1,042,698,970	-4.49
TWO PLAN MODEL	$13,902,387,070	$13,414,476,690	-$487,910,380	-3.51
COUNTY ORGANIZED HEALTH SYST	$6,443,040,490	$6,095,838,250	-$347,202,240	-5.39
GEOGRAPHIC MANAGED CARE	$2,321,861,310	$2,194,553,170	-$127,308,140	-5.48
PHP & OTHER MANAG. CARE	$563,749,090	$483,470,870	-$80,278,220	-14.24
DENTAL	$632,838,310	$553,127,750	-$79,710,560	-12.60
MENTAL HEALTH	$1,796,083,700	$1,668,432,240	-$127,651,470	-7.11
AUDITS/ LAWSUITS	-$69,007,390	-$75,434,780	-$6,427,400	9.31
EPSDT SCREENS	$37,239,130	$37,965,360	$726,230	1.95
MEDICARE PAYMENTS	$4,037,588,000	$3,967,162,000	-$70,426,000	-1.74
STATE HOSP./DEVELOPMENTAL CNTRS.	$262,208,690	$266,006,860	$3,798,160	1.45
MISC. SERVICES	$12,232,288,220	$7,745,799,460	-$4,486,488,760	-36.68
RECOVERIES	-$262,990,000	-$312,935,000	-$49,945,000	18.99
GRAND TOTAL MEDI-CAL	**$65,641,006,870**	**$58,665,021,860**	**-$6,975,985,010**	**-10.63**
STATE FUNDS	**$25,081,180,330**	**$21,802,906,170**	**-$3,278,274,160**	**-13.07**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	ELIGIBILITY										
2	FAMILY PACT PROGRAM	$645,619,000	$161,547,900	$632,717,000	$158,474,900	$576,793,000	$144,468,000	-$68,826,000	-$17,079,900	-$55,924,000	-$14,006,900
3	BREAST AND CERVICAL CANCER TREATMENT	$142,761,000	$62,727,800	$154,126,000	$67,664,450	$149,256,000	$65,896,100	$6,495,000	$3,168,300	-$4,870,000	-$1,768,350
4	AIM LINKED INFANTS 250-300% FPL	$33,357,000	$11,674,950	$33,357,000	$11,674,950	$31,629,000	$11,070,150	-$1,728,000	-$604,800	-$1,728,000	-$604,800
5	MEDI-CAL ADULT INMATE PROGRAMS	$21,669,000	$0	$12,557,000	$0	$14,092,000	$0	-$7,577,000	$0	$1,535,000	$0
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES	$6,932,000	$0	$6,467,000	$0	$4,518,000	$0	-$2,414,000	$0	-$1,949,000	$0
8	REFUGEES	$5,199,000	$5,199,000	$5,887,000	$5,887,000	$5,878,000	$5,878,000	$679,000	$679,000	-$9,000	-$9,000
11	NEW QUALIFIED IMMIGRANTS	$0	$68,153,000	$0	$63,554,000	$0	$62,996,000	$0	-$5,157,000	$0	-$558,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	-$54,200,850	$0	-$56,409,300	$0	-$86,060,700	$0	-$31,859,850	$0	-$29,651,400
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	-$9,072,100	$0	-$8,901,500	$0	-$8,927,700	$0	$144,400	$0	-$26,200
14	INCARCERATION VERIFICATION PROGRAM	-$168,000	-$84,000	-$211,000	-$105,500	-$255,000	-$127,500	-$87,000	-$43,500	-$44,000	-$22,000
15	PARIS-FEDERAL	-$6,634,000	-$3,317,000	-$7,682,000	-$3,841,000	-$10,470,000	-$5,235,000	-$3,836,000	-$1,918,000	-$2,788,000	-$1,394,000
16	PARIS-VETERANS	-$1,678,250	-$839,130	-$3,542,510	-$1,771,260	-$2,541,570	-$1,270,780	-$863,320	-$431,660	$1,000,950	$500,470
17	PARIS-INTERSTATE	-$22,339,000	-$11,169,500	-$26,010,000	-$13,005,000	-$23,631,000	-$11,815,500	-$1,292,000	-$646,000	$2,379,000	$1,189,500
--	250% WORKING DISABLED PROGRAM CHANGES	$2,320,000	$1,560,000	$0	$0	$0	$0	-$2,320,000	-$1,560,000	$0	$0
--	CHDP GATEWAY - PREENROLLMENT	$15,022,000	$5,257,700	$11,937,000	$4,177,950	$0	$0	-$15,022,000	-$5,257,700	-$11,937,000	-$4,177,950
--	LOMELI V. SHEWRY	$504,000	$252,000	$0	$0	$0	$0	-$504,000	-$252,000	$0	$0
--	MCHA VS. DHCS AND MRMIB	$540,000	$270,000	$540,000	$270,000	$0	$0	-$540,000	-$270,000	-$540,000	-$270,000
--	TRANSITION OF HFP TO MEDI-CAL	$1,103,252,000	$386,138,200	$1,195,670,000	$418,484,500	$0	$0	-$1,103,252,000	-$386,138,200	-$1,195,670,000	-$418,484,500
	ELIGIBILITY SUBTOTAL	**$1,946,355,750**	**$624,097,970**	**$2,015,812,490**	**$646,154,190**	**$745,268,430**	**$176,871,070**	**-$1,201,087,320**	**-$447,226,910**	**-$1,270,544,060**	**-$469,283,130**
	AFFORDABLE CARE ACT										
18	ACA OPTIONAL EXPANSION	$1,426,631,000	$0	$2,609,318,000	$0	$2,857,646,000	$1,768,000	$1,431,015,000	$1,768,000	$248,328,000	$1,768,000
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	$1,357,030,130	$123,183,190	$1,661,805,710	$33,670,960	$1,629,619,590	$28,647,910	$272,589,460	-$94,535,280	-$32,186,120	-$5,023,050
20	COMMUNITY FIRST CHOICE OPTION	$322,584,000	$0	$238,923,000	$0	$244,263,000	$0	-$78,321,000	$0	$5,340,000	$0
21	ACA MANDATORY EXPANSION	$228,164,000	$107,800,000	$222,825,000	$103,754,350	$419,928,000	$193,414,050	$191,764,000	$85,614,050	$197,103,000	$89,659,700
22	MENTAL HEALTH SERVICES EXPANSION	$79,315,000	$31,910,000	$73,695,000	$28,427,000	$86,512,000	$31,682,650	$7,197,000	-$227,350	$12,817,000	$3,255,650
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	$24,631,000	$0	$24,252,000	$0	$33,935,000	$0	$9,304,000	$0	$9,683,000	$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$0	$0	$18,672,000	$9,168,500	$10,390,000	$2,202,400	$10,390,000	$2,202,400	-$8,282,000	-$6,966,100
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	-$7,205,000	-$2,654,000	$14,493,000	$5,254,000	$14,493,000	$5,254,000	$21,698,000	$7,908,000	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	AFFORDABLE CARE ACT										
27	USPSTF GRADE A AND B RECOMMENDATIONS	$0	$0	$9,673,000	$3,711,000	$11,693,440	$4,291,650	$11,693,440	$4,291,650	$2,020,440	$580,650
28	ACA DELAY OF REDETERMINATIONS	$0	$0	$6,653,000	$2,052,850	$150,904,000	$70,579,550	$150,904,000	$70,579,550	$144,251,000	$68,526,700
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	$803,000	$803,000	$796,000	$796,000	$0	$115,000	-$803,000	-$688,000	-$796,000	-$681,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	-$7,500,000	$0	-$40,284,000	$0	-$45,932,000	$0	-$38,432,000	$0	-$5,648,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-$43,510	-$21,750	-$10,530	-$5,270	-$2,060	-$1,030	$41,450	$20,720	$8,470	$4,240
34	MANAGED CARE DRUG REBATES	-$348,403,000	-$174,201,500	-$388,347,000	-$194,173,500	-$379,500,000	-$189,750,000	-$31,097,000	-$15,548,500	$8,847,000	$4,423,500
206	ACA EXPRESS LANE ENROLLMENT	$0	$0	$71,535,000	$1,204,400	$413,611,000	$5,975,800	$413,611,000	$5,975,800	$342,076,000	$4,771,400
217	ACA MAGI SAVINGS	$0	$0	$0	$0	$0	-$2,303,000	$0	-$2,303,000	$0	-$2,303,000
--	ACA EXPANSION-LTSS FOR OPTIONAL EXPANSION	$251,173,000	$0	$0	$0	$0	$0	-$251,173,000	$0	$0	$0
--	ACA EXPANSION-PREGNANCY ONLY	-$52,047,000	-$26,023,500	$0	$0	$0	$0	$52,047,000	$26,023,500	$0	$0
--	DISPROPORTIONATE SHARE HOSPITAL REDUCTION	-$70,421,000	-$24,691,500	-$43,634,000	-$13,730,000	$0	$0	$70,421,000	$24,691,500	$43,634,000	$13,730,000
--	ENHANCE DRUG MEDI-CAL SVCS	$80,025,000	$34,771,000	$0	$0	$0	$0	-$80,025,000	-$34,771,000	$0	$0
--	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION	-$24,013,000	-$12,006,500	-$15,687,000	-$7,843,500	$0	$0	$24,013,000	$12,006,500	$15,687,000	$7,843,500
	AFFORDABLE CARE ACT SUBTOTAL	**$3,268,223,620**	**$51,368,440**	**$4,504,962,180**	**-$67,997,210**	**$5,493,492,970**	**$105,944,980**	**$2,225,269,350**	**$54,576,540**	**$988,530,790**	**$173,942,190**
	BENEFITS										
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$259,483,000	$0	$206,024,000	$0	$182,932,000	$0	-$76,551,000	$0	-$23,092,000	$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$142,840,000	$0	$145,537,000	$0	$144,983,000	$0	$2,143,000	$0	-$554,000	$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$32,651,000	$3,968,000	$51,410,000	$1,474,000	$45,621,000	$1,478,000	$12,970,000	-$2,490,000	-$5,789,000	$4,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFITS	$51,057,000	$15,520,000	$10,888,000	$3,315,500	$9,121,000	$3,173,000	-$41,936,000	-$12,347,000	-$1,767,000	-$142,500
39	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$40,464,000	$20,232,000	$40,464,000	$20,232,000	$40,464,000	$20,232,000	$0	$0	$0	$0
40	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS	$27,637,000	$13,818,500	$39,990,000	$19,995,000	$34,320,000	$17,160,000	$6,683,000	$3,341,500	-$5,670,000	-$2,835,000
41	YOUTH REGIONAL TREATMENT CENTERS	$5,688,000	-$711,000	$5,085,000	$776,000	$3,910,000	$776,000	-$1,778,000	$1,487,000	-$1,175,000	$0
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING	$4,506,000	$2,253,000	$4,631,000	$2,315,500	$4,631,000	$2,315,500	$125,000	$62,500	$0	$0
43	CCT FUND TRANSFER TO CDSS AND CDDS	$4,227,000	$0	$2,678,000	$0	$2,477,000	$0	-$1,750,000	$0	-$201,000	$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$540,000	$270,000	$540,000	$270,000	$0	$0	$0	$0
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$337,000	$0	$183,000	$0	$226,000	$0	-$111,000	$0	$43,000	$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$170,000	$0	$131,000	$0	$139,000	$0	-$31,000	$0	$8,000	$0
49	SCHIP FUNDING FOR PRENATAL CARE	$0	-$89,878,100	$0	-$92,051,700	$0	-$89,107,200	$0	$770,900	$0	$2,944,500
51	WOMEN'S HEALTH SERVICES	$0	$0	-$8,289,990	-$3,398,820	-$2,237,990	-$2,086,550	-$2,237,990	-$2,086,550	$6,052,000	$1,312,270

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	BENEFITS										
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$23,880,000	-$11,940,000	-$13,558,000	-$6,779,000	-$14,073,000	-$7,036,500	$9,807,000	$4,903,500	-$515,000	-$257,500
66	VOLUNTARY INPATIENT DETOXIFICATION	$0	$0	$9,468,000	$4,030,000	$10,179,000	$4,092,500	$10,179,000	$4,092,500	$711,000	$62,500
--	ADHC TRANSITION-BENEFITS	$281,754,000	$140,877,000	$0	$0	$0	$0	-$281,754,000	-$140,877,000	$0	$0
--	COPAYMENT FOR NON-EMERGENCY ER VISITS	-$33,707,000	-$16,853,500	$0	$0	$0	$0	$33,707,000	$16,853,500	$0	$0
--	ELIMINATION OF OTC COUGH AND COLD PRODUCTS	-$4,432,000	-$2,216,000	$0	$0	$0	$0	$4,432,000	$2,216,000	$0	$0
--	FAMILY PACT RETROACTIVE ELIGIBILITY	$3,000	$300	$0	$0	$0	$0	-$3,000	-$300	$0	$0
--	HEARING AID CAP	-$1,434,000	-$717,000	-$1,434,000	-$717,000	$0	$0	$1,434,000	$717,000	$1,434,000	$717,000
--	INCREASED FEDERAL MATCHING FUNDS FOR FPACT	$0	-$3,794,100	$0	-$3,794,100	$0	$0	$0	$3,794,100	$0	$3,794,100
	BENEFITS SUBTOTAL	**$787,904,000**	**$70,829,100**	**$493,747,010**	**-$54,332,620**	**$463,232,010**	**-$48,733,250**	**-$324,671,990**	**-$119,562,350**	**-$30,515,000**	**$5,599,370**
	PHARMACY										
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	$3,356,000	$1,678,000	$3,356,000	$1,678,000	$3,383,020	$1,691,510	$27,020	$13,510	$27,020	$13,510
54	NON FFP DRUGS	$0	$1,912,000	$0	$1,920,000	$0	$2,044,500	$0	$132,500	$0	$124,500
55	BCCTP DRUG REBATES	-$16,000,000	-$5,600,000	-$15,389,000	-$5,386,150	-$15,389,000	-$5,386,150	$611,000	$213,850	$0	$0
56	MEDICAL SUPPLY REBATES	-$19,476,000	-$9,738,000	-$18,321,000	-$9,160,500	-$24,428,000	-$12,214,000	-$4,952,000	-$2,476,000	-$6,107,000	-$3,053,500
57	FAMILY PACT DRUG REBATES	-$73,946,000	-$9,675,000	-$72,232,000	-$9,248,400	-$78,108,000	-$10,000,800	-$4,162,000	-$325,800	-$5,876,000	-$752,400
58	LITIGATION SETTLEMENTS	$0	$0	-$81,772,000	-$81,772,000	-$88,253,000	-$88,253,000	-$88,253,000	-$88,253,000	-$6,481,000	-$6,481,000
59	AGED AND DISPUTED DRUG REBATES	-$135,000,000	-$67,433,600	-$150,000,000	-$74,611,200	-$286,000,000	-$142,973,600	-$151,000,000	-$75,540,000	-$136,000,000	-$68,362,400
60	STATE SUPPLEMENTAL DRUG REBATES	-$152,549,000	-$76,153,300	-$165,789,000	-$82,464,900	-$209,567,000	-$102,848,700	-$57,018,000	-$26,695,400	-$43,778,000	-$20,383,800
61	FEDERAL DRUG REBATE PROGRAM	-$1,258,766,000	-$572,381,400	-$1,335,187,000	-$608,132,700	-$1,378,767,000	-$599,064,200	-$120,001,000	-$26,682,800	-$43,580,000	$9,068,500
--	IMPLEMENTATION OF SPECIALTY DRUG CONTRACTS	-$13,985,390	-$6,992,690	$0	$0	$0	$0	$13,985,390	$6,992,690	$0	$0
--	KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS	$4,800,000	$2,400,000	$0	$0	$0	$0	-$4,800,000	-$2,400,000	$0	$0
--	PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT	-$15,157,000	-$7,578,500	$0	$0	$0	$0	$15,157,000	$7,578,500	$0	$0
--	SUNSET OF SPECIALTY DRUG CONTRACTS	$13,985,390	$6,992,690	$0	$0	$0	$0	-$13,985,390	-$6,992,690	$0	$0
	PHARMACY SUBTOTAL	**-$1,662,738,000**	**-$742,569,800**	**-$1,835,334,000**	**-$867,177,850**	**-$2,077,128,980**	**-$957,004,440**	**-$414,390,980**	**-$214,434,640**	**-$241,794,980**	**-$89,826,590**
	DRUG MEDI-CAL										
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	-$1,859,000	$0	$3,036,000	$0	$3,036,000	$0	$4,895,000	$0	$0	$0
--	ANNUAL RATE ADJUSTMENT	-$1,627,000	$0	$0	$0	$0	$0	$1,627,000	$0	$0	$0
	DRUG MEDI-CAL SUBTOTAL	**-$3,486,000**	**$0**	**$3,036,000**	**$0**	**$3,036,000**	**$0**	**$6,522,000**	**$0**	**$0**	**$0**
	MENTAL HEALTH										

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MENTAL HEALTH										
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT	$293,819,000	$0	$293,819,000	$0	$64,187,000	$0	-$229,632,000	$0	-$229,632,000	$0
72	ELIMINATION OF STATE MAXIMUM RATES	$124,484,000	$0	$124,190,000	$0	$67,962,000	$0	-$56,522,000	$0	-$56,228,000	$0
73	TRANSITION OF HFP - SMH SERVICES	$32,731,000	$0	$32,619,000	$0	$29,886,000	$0	-$2,845,000	$0	-$2,733,000	$0
74	KATIE A. V. DIANA BONTA	$23,161,000	$0	$27,955,000	$0	$29,293,000	$0	$6,132,000	$0	$1,338,000	$0
75	HEALTHY FAMILIES - SED	$22,250,000	$0	$18,731,000	$0	$18,769,000	$0	-$3,481,000	$0	$38,000	$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	$24,800,000	$0	$12,400,000	$0	$12,400,000	$0	-$12,400,000	$0	$0	$0
77	OVER ONE-YEAR CLAIMS	$3,000,000	$0	$3,000,000	$0	$3,353,000	$0	$353,000	$0	$353,000	$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	$2,769,000	$0	$2,270,000	$0	$2,270,000	$0	-$499,000	$0	$0	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT	$0	$0	$0	$7,204,000	$0	$7,204,000	$0	$7,204,000	$0	$0
80	IMD ANCILLARY SERVICES	$0	$6,000,000	$0	$6,000,000	$0	$6,000,000	$0	$0	$0	$0
81	CHART REVIEW	-$580,000	$0	-$1,475,000	$0	-$1,271,000	$0	-$691,000	$0	$204,000	$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-$70,714,000	$39,385,000	-$41,760,000	$27,777,000	-$41,760,000	$27,777,000	$28,954,000	-$11,608,000	$0	$0
--	PAROLE MENTAL HEALTH AND MEDI-CAL EXPANSION	$7,181,000	$0	$0	$0	$0	$0	-$7,181,000	$0	$0	$0
--	REIMBURSEMENT IN IMD ANCILLARY SERVICES COSTS	-$12,000,000	-$12,000,000	-$12,000,000	-$12,000,000	$0	$0	$12,000,000	$12,000,000	$12,000,000	$12,000,000
	MENTAL HEALTH SUBTOTAL	**$450,901,000**	**$33,385,000**	**$459,749,000**	**$28,981,000**	**$185,089,000**	**$40,981,000**	**-$265,812,000**	**$7,596,000**	**-$274,660,000**	**$12,000,000**
	WAIVER--MH/UCD & BTR										
84	BTR - LIHP - MCE	$4,770,999,000	$2,090,531,000	$5,495,397,000	$2,338,785,500	$1,039,826,000	$127,029,500	-$3,731,173,000	-$1,963,501,500	-$4,455,571,000	-$2,211,756,000
85	MH/UCD & BTR—DSH PAYMENT	$1,774,361,000	$622,248,000	$1,599,070,000	$344,527,000	$1,655,852,000	$396,202,000	-$118,509,000	-$226,046,000	$56,782,000	$51,675,000
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL	$1,435,292,000	$717,646,000	$1,485,648,000	$742,824,000	$1,474,435,000	$737,217,500	$39,143,000	$19,571,500	-$11,213,000	-$5,606,500
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT	$546,058,000	$273,029,000	$603,508,000	$301,754,000	$608,376,000	$304,188,000	$62,318,000	$31,159,000	$4,868,000	$2,434,000
88	BTR—SAFETY NET CARE POOL	$317,250,000	$0	$317,250,000	$0	$317,250,000	$0	$0	$0	$0	$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENTS	$339,269,000	$169,634,500	$248,602,000	$124,301,000	$250,602,000	$125,301,000	-$88,667,000	-$44,333,500	$2,000,000	$1,000,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$161,299,000	$13,470,000	$180,186,000	$44,904,000	$134,376,000	$23,076,000	-$26,923,000	$9,606,000	-$45,810,000	-$21,828,000
91	MH/UCD & BTR—CCS AND GHPP	$130,627,000	$0	$129,858,000	$0	$134,565,000	$0	$3,938,000	$0	$4,707,000	$0
92	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	$110,000,000	$55,000,000	$110,000,000	$55,000,000	$110,000,000	$55,000,000	$0	$0	$0	$0
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND	$126,400,000	$63,200,000	$100,000,000	$50,000,000	$19,933,000	$12,095,000	-$106,467,000	-$51,105,000	-$80,067,000	-$37,905,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$77,960,000	$0	$82,000,000	$0	$84,400,000	$0	$6,440,000	$0	$2,400,000	$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	$66,339,000	-$279,331,000	$66,339,000	-$331,197,000	$8,315,000	-$246,770,000	-$58,024,000	$32,561,000	-$58,024,000	$84,427,000
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES	$29,503,000	$0	$56,473,000	$0	$53,642,000	$0	$24,139,000	$0	-$2,831,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR										
98	BTR—INCREASE SAFETY NET CARE POOL	$24,500,000	$0	$30,750,000	$0	$24,250,000	$0	-$250,000	$0	-$6,500,000	$0
99	MH/UCD—STABILIZATION FUNDING	$39,911,000	$29,154,000	$13,988,000	$13,988,000	$13,988,000	$13,988,000	-$25,923,000	-$15,166,000	$0	$0
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$159,300,000	$0	$11,877,000	$0	$11,877,000	$0	-$147,423,000	$0	$0	$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG	$23,142,000	$0	$10,193,000	$0	$3,786,000	$0	-$19,356,000	$0	-$6,407,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$31,467,000	$0	$9,613,000	$0	$9,500,000	$0	-$21,967,000	$0	-$113,000	$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$8,141,000	$4,070,500	$8,510,000	$4,255,000	$7,600,000	$3,800,000	-$541,000	-$270,500	-$910,000	-$455,000
104	MH/UCD—SAFETY NET CARE POOL	$154,500,000	$0	$1,949,000	$0	$1,949,000	$0	-$152,551,000	$0	$0	$0
105	MH/UCD & BTR—MIA-LTC	$0	-$19,518,000	$0	-$19,327,000	$0	-$19,327,000	$0	$191,000	$0	$0
106	MH/UCD & BTR—BCCTP	$0	-$1,423,000	$0	-$1,786,000	$0	-$1,786,000	$0	-$363,000	$0	$0
107	MH/UCD & BTR—DPH INTERIM RATE	$0	-$560,037,000	$0	-$441,435,000	$0	-$365,021,500	$0	$195,015,500	$0	$76,413,500
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS	$0	-$24,500,000	$0	-$30,750,000	$0	-$24,250,000	$0	$250,000	$0	$6,500,000
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	-$28,925,000	$0	-$20,762,000	$0	$24,503,000	$0	$53,428,000	$0	$45,265,000
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS	$49,000,000	$0	-$61,500,000	$0	-$48,500,000	$0	$500,000	$0	$13,000,000	$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-$116,524,360	-$58,262,180	-$77,897,380	-$38,948,690	-$80,809,280	-$40,404,640	$35,715,080	$17,857,540	-$2,911,910	-$1,455,950
--	HOSPITAL STABILIZATION	-$36,618,000	-$18,309,000	$0	$0	$0	$0	$36,618,000	$18,309,000	$0	$0
--	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$116,992,000	$58,496,000	$48,791,390	$24,395,690	$0	$0	-$116,992,000	-$58,496,000	-$48,791,390	-$24,395,690
--	PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS	-$46,000,000	-$23,000,000	$0	$0	$0	$0	$46,000,000	$23,000,000	$0	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$10,195,167,640**	**$3,083,173,820**	**$10,470,605,010**	**$3,160,528,510**	**$5,835,212,720**	**$1,124,840,860**	**-$4,359,954,920**	**-$1,958,332,960**	**-$4,635,392,290**	**-$2,035,687,650**
	MANAGED CARE										
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$812,173,000	$406,086,500	$783,819,000	$345,594,000	$798,599,000	$331,195,000	-$13,574,000	-$74,891,500	$14,780,000	-$14,399,000
118	MANAGED CARE RATE RANGE IGTS	$500,119,000	$245,938,000	$744,394,000	$355,300,000	$739,514,000	$343,686,000	$239,395,000	$97,748,000	-$4,880,000	-$11,614,000
119	CCI-MANAGED CARE PAYMENTS	$1,665,138,000	$817,466,000	$125,278,000	$61,273,500	$98,877,000	$49,438,500	-$1,566,261,000	-$768,027,500	-$26,401,000	-$11,835,000
120	MANAGED CARE PUBLIC HOSPITAL IGTS	$678,988,000	$339,494,000	$443,548,000	$221,774,000	$783,992,000	$391,996,000	$105,004,000	$52,502,000	$340,444,000	$170,222,000
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES	$332,796,000	$166,398,000	$383,441,000	$191,720,500	$371,327,000	$185,663,500	$38,531,000	$19,265,500	-$12,114,000	-$6,057,000
123	CCI-TRANSFER OF IHSS COSTS TO CDSS	$503,439,000	$503,439,000	$45,505,000	$45,505,000	$39,821,000	$39,821,000	-$463,618,000	-$463,618,000	-$5,684,000	-$5,684,000
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	$161,079,000	$80,539,500	$21,097,000	$10,548,500	$1,079,000	$539,500	-$160,000,000	-$80,000,000	-$20,018,000	-$10,009,000
128	INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX	$5,512,000	$2,711,000	$8,862,000	$4,358,000	$8,236,000	$4,050,050	$2,724,000	$1,339,050	-$626,000	-$307,950
131	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0	$0	$0
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE										
134	EXTEND GROSS PREMIUM TAX	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
135	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
136	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
138	FFS COSTS FOR MANAGED CARE ENROLLEES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
140	MCO TAX MANAGED CARE PLANS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
143	CCI-SAVINGS AND DEFERRAL	-$1,152,958,000	-$576,479,000	-$140,711,000	-$70,355,500	-$76,030,000	-$38,015,000	$1,076,928,000	$538,464,000	$64,681,000	$32,340,500
--	ALIGN MANAGED CARE BENEFIT POLICIES	$106,752,000	$53,376,000	$0	$0	$0	$0	-$106,752,000	-$53,376,000	$0	$0
--	DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC	-$535,000	-$267,500	-$1,100,000	-$550,000	$0	$0	$535,000	$267,500	$1,100,000	$550,000
--	MANAGED CARE COST-BASED REIMBURSEMENT CLINICS	$174,700,000	$87,350,000	$0	$0	$0	$0	-$174,700,000	-$87,350,000	$0	$0
--	MANAGED CARE DEFAULT ASSIGNMENT	-$4,531,000	-$2,265,500	$0	$0	$0	$0	$4,531,000	$2,265,500	$0	$0
--	POTENTIALLY PREVENTABLE ADMISSIONS	-$39,634,000	-$19,817,000	$0	$0	$0	$0	$39,634,000	$19,817,000	$0	$0
--	RETRO MC RATE ADJUSTMENTS	$105,531,000	$52,765,500	$338,810,000	$169,405,000	$0	$0	-$105,531,000	-$52,765,500	-$338,810,000	-$169,405,000
--	SCAN TRANSITION TO MANAGED CARE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	MANAGED CARE SUBTOTAL	**$3,850,569,000**	**$2,158,734,500**	**$2,754,943,000**	**$1,336,573,000**	**$2,767,415,000**	**$1,310,374,550**	**-$1,083,154,000**	**-$848,359,950**	**$12,472,000**	**-$26,198,450**
	PROVIDER RATES										
24	AB 1629 ADD-ONS	$161,173,530	$80,586,760	$19,207,540	$9,603,770	$3,138,740	$1,569,370	-$158,034,780	-$79,017,390	-$16,068,800	-$8,034,400
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	$197,403,690	$98,701,840	$273,342,660	$136,671,330	$256,869,140	$128,434,570	$59,465,460	$29,732,730	-$16,473,510	-$8,236,760
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$27,686,000	$13,843,000	$68,001,180	$34,000,590	$5,078,260	$2,539,130	-$22,607,740	-$11,303,870	-$62,922,910	-$31,461,460
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS	$37,578,000	$16,877,000	$40,673,000	$20,336,500	$45,489,000	$22,744,500	$7,911,000	$5,867,500	$4,816,000	$2,408,000
147	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$18,219,000	$9,110,000	$18,459,860	$9,229,930	$22,000,000	$11,000,000	$3,781,000	$1,890,000	$3,540,140	$1,770,070
148	LTC RATE ADJUSTMENT	$91,642,710	$45,821,350	$17,484,220	$8,742,110	$13,411,550	$6,705,770	-$78,231,160	-$39,115,580	-$4,072,670	-$2,036,330
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$17,910,830	$8,955,420	$60,321,980	$30,160,990	$15,551,300	$7,775,650	-$2,359,530	-$1,179,770	-$44,770,680	-$22,385,340
150	HOSPICE RATE INCREASES	$10,437,740	$5,218,870	$4,416,510	$2,208,250	$4,461,220	$2,230,610	-$5,976,520	-$2,988,260	$44,710	$22,350
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
152	NON-AB 1629 LTC RATE FREEZE	-$72,468,610	-$36,234,310	-$1,872,000	-$936,000	-$30,000	-$15,000	$72,438,610	$36,219,310	$1,842,000	$921,000
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$71,347,000	-$35,673,500	-$13,035,000	-$6,517,500	-$1,773,850	-$886,920	$69,573,150	$34,786,580	$11,261,150	$5,630,580
157	10% PROVIDER PAYMENT REDUCTION	-$1,041,964,000	-$520,982,000	-$312,677,000	-$156,338,500	-$278,751,530	-$139,375,770	$763,212,470	$381,606,230	$33,925,470	$16,962,730

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NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PROVIDER RATES										
--	DENTAL RETROACTIVE RATE CHANGES	-$2,000,000	-$1,000,000	-$4,782,000	-$2,391,000	$0	$0	$2,000,000	$1,000,000	$4,782,000	$2,391,000
--	ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMENT	-$51,473,000	-$25,736,500	$0	$0	$0	$0	$51,473,000	$25,736,500	$0	$0
--	LABORATORY RATE METHODOLOGY CHANGE	-$13,223,630	-$6,611,810	-$8,477,900	-$4,238,950	$0	$0	$13,223,630	$6,611,810	$8,477,900	$4,238,950
--	REDUCTION TO RADIOLOGY RATES	-$58,264,940	-$29,132,470	-$28,638,160	-$14,319,080	$0	$0	$58,264,940	$29,132,470	$28,638,160	$14,319,080
	PROVIDER RATES SUBTOTAL	**-$748,689,680**	**-$376,256,340**	**$132,424,880**	**$66,212,440**	**$85,443,840**	**$42,721,920**	**$834,133,520**	**$418,978,260**	**-$46,981,040**	**-$23,490,520**
	SUPPLEMENTAL PMNTS.										
158	HOSPITAL QAF - HOSPITAL PAYMENTS	$4,212,457,000	$2,127,154,000	$4,209,680,000	$2,114,955,000	$3,767,106,000	$1,894,165,000	-$445,351,000	-$232,989,000	-$442,574,000	-$220,790,000
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$160,000,000	$0	$190,500,000	$0	$100,000,000	$0	-$60,000,000	$0	-$90,500,000	$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$205,995,000	$0	$179,174,000	$0	$172,138,000	$0	-$33,857,000	$0	-$7,036,000	$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	$140,000,000	$70,000,000	$140,000,000	$70,000,000	$135,742,000	$67,871,000	-$4,258,000	-$2,129,000	-$4,258,000	-$2,129,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	$44,145,000	$0	$117,889,000	$0	$89,899,000	$0	$45,754,000	$0	-$27,990,000	$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	$112,557,000	$46,043,000	$117,187,000	$48,689,500	$120,632,000	$50,412,000	$8,075,000	$4,369,000	$3,445,000	$1,722,500
166	FFP FOR LOCAL TRAUMA CENTERS	$82,000,000	$41,000,000	$100,000,000	$50,000,000	$100,000,000	$50,000,000	$18,000,000	$9,000,000	$0	$0
167	IGT PAYMENTS FOR HOSPITAL SERVICES	$15,000,000	$7,500,000	$15,000,000	$7,500,000	$11,000,000	$5,500,000	-$4,000,000	-$2,000,000	-$4,000,000	-$2,000,000
168	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0	$0	$0
169	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0	$0	$0
170	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$3,600,000	$0	$5,475,000	$0	$4,725,000	$0	$1,125,000	$0	-$750,000	$0
--	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$2,438,060,000	$1,223,680,000	$2,261,177,000	$1,137,338,000	$0	$0	-$2,438,060,000	-$1,223,680,000	-$2,261,177,000	-$1,137,338,000
--	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$455,989,000	$0	$455,989,000	$0	$0	$0	-$455,989,000	$0	-$455,989,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$7,887,803,000**	**$3,524,377,000**	**$7,810,071,000**	**$3,437,482,500**	**$4,519,242,000**	**$2,076,948,000**	**-$3,368,561,000**	**-$1,447,429,000**	**-$3,290,829,000**	**-$1,360,534,500**
	OTHER										
177	ARRA HITECH - PROVIDER PAYMENTS	$395,625,000	$0	$240,434,000	$0	$315,564,000	$0	-$80,061,000	$0	$75,130,000	$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS	$198,021,000	$0	$133,245,000	$0	$120,670,000	$0	-$77,351,000	$0	-$12,575,000	$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	$2,177,000	$1,088,500	$11,487,000	$5,743,500	$72,905,000	$36,452,500	$70,728,000	$35,364,000	$61,418,000	$30,709,000
184	CDDS DENTAL SERVICES	$11,430,000	$11,430,000	$11,430,000	$11,430,000	$11,972,000	$11,972,000	$542,000	$542,000	$542,000	$542,000
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$11,418,000	$5,709,000	$20,565,000	$8,740,000	$20,565,000	$8,740,000	$9,147,000	$3,031,000	$0	$0
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$0	$0	$7,837,000	$2,351,000	$3,918,000	$1,175,000	$3,918,000	$1,175,000	-$3,919,000	-$1,176,000
187	AUDIT SETTLEMENTS	$6,298,000	$6,298,000	$8,247,000	$8,247,000	$8,247,000	$8,247,000	$1,949,000	$1,949,000	$0	$0
191	INDIAN HEALTH SERVICES	$2,524,000	-$9,273,500	$1,254,000	-$9,435,500	$1,254,000	-$9,435,500	-$1,270,000	-$162,000	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFF. MAY TO APPROPRIATION		DIFF. MAY TO NOV.	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER										
192	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
194	CLPP FUND	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
201	IHSS REDUCTION IN SERVICE HOURS	-$154,157,000	$0	-$196,331,000	$0	-$218,342,000	$0	-$64,185,000	$0	-$22,011,000	$0
--	AB 97 INJUNCTIONS	$195,701,000	$97,850,500	$0	$0	$0	$0	-$195,701,000	-$97,850,500	$0	$0
--	ANTI-FRAUD ACTIVITIES	-$13,800,000	-$6,900,000	-$15,000,000	-$7,500,000	$0	$0	$13,800,000	$6,900,000	$15,000,000	$7,500,000
--	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
--	FQHC/RHC AUDIT STAFFING	-$12,723,000	-$6,361,500	$0	$0	$0	$0	$12,723,000	$6,361,500	$0	$0
--	MEDICARE BUY-IN QUALITY REVIEW PROJECT	-$4,000,000	-$3,800,000	-$4,000,000	-$3,800,000	$0	$0	$4,000,000	$3,800,000	$4,000,000	$3,800,000
--	OPERATIONAL FLEXIBILITIES	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
--	OVERPAYMENTS - INTEREST RATE CHANGE	-$3,112,000	-$3,112,000	$0	$0	$0	$0	$3,112,000	$3,112,000	$0	$0
--	TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	OTHER SUBTOTAL	**$635,402,000**	**$92,929,000**	**$219,168,000**	**$15,776,000**	**$336,753,000**	**$57,151,000**	**-$298,649,000**	**-$35,778,000**	**$117,585,000**	**$41,375,000**
	GRAND TOTAL	**$26,607,412,330**	**$8,520,068,690**	**$27,029,184,570**	**$7,702,199,960**	**$18,357,055,990**	**$3,930,095,680**	**-$8,250,356,340**	**-$4,589,973,010**	**-$8,672,128,570**	**-$3,772,104,280**

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

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	PA-OAS	PA-AB	PA-ATD	PA-AFDC	LT-OAS	LT-AB
PHYSICIANS	$40,948,670	$4,408,440	$193,502,310	$64,331,610	$6,096,520	$107,580
OTHER MEDICAL	$81,070,320	$10,747,840	$419,835,910	$291,032,900	$9,688,740	$307,500
COUNTY OUTPATIENT	$464,030	$87,830	$7,280,590	$1,649,720	$182,530	$2,040
COMMUNITY OUTPATIENT	$9,473,690	$1,850,430	$161,159,120	$27,691,810	$804,180	$11,060
PHARMACY	$9,181,100	$4,757,120	$319,969,570	$33,627,540	$3,428,190	$61,140
COUNTY INPATIENT	$6,194,070	$789,310	$54,928,360	$20,628,080	$1,790,190	$2,660
COMMUNITY INPATIENT	$128,154,840	$15,713,150	$802,338,000	$259,259,410	$31,031,810	$440,540
NURSING FACILITIES	$536,907,220	$22,806,340	$805,788,640	$3,020,950	$1,948,555,770	$7,917,200
ICF-DD	$408,250	$8,326,620	$169,458,110	$301,520	$29,404,550	$3,143,260
MEDICAL TRANSPORTATION	$19,305,310	$3,940,460	$51,620,530	$4,026,950	$5,647,950	$121,270
OTHER SERVICES	$68,012,110	$7,240,470	$156,281,640	$37,083,390	$85,653,790	$254,440
HOME HEALTH	$426,020	$11,662,140	$140,062,620	$4,145,370	$53,060	$0
FFS SUBTOTAL	**$900,545,610**	**$92,330,140**	**$3,282,225,390**	**$746,799,240**	**$2,122,337,290**	**$12,368,680**
DENTAL	$26,786,470	$1,369,290	$62,948,000	$89,617,210	$2,942,380	$14,450
TWO PLAN MODEL	$345,670,650	$61,281,510	$3,689,594,590	$1,677,979,890	-$209,220	-$209,220
COUNTY ORGANIZED HEALTH SYSTEMS	$260,474,670	$22,731,510	$1,146,419,270	$353,835,900	$644,631,630	$1,656,520
GEOGRAPHIC MANAGED CARE	$59,682,240	$10,967,850	$653,457,860	$278,075,620	-$36,070	-$36,070
PHP & OTHER MANAG. CARE	$100,349,630	$2,266,470	$61,683,150	$47,314,810	$4,611,800	$4,250
EPSDT SCREENS	$0	$0	$0	$8,346,500	$0	$0
MEDICARE PAYMENTS	$1,351,239,560	$40,049,280	$1,264,768,430	$0	$144,135,980	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$104,390	$1,487,550	$56,709,630	$548,050	$13,466,250	$1,017,800
MISC. SERVICES	$655,057,180	$34,041,110	$3,121,222,330	$810,320	$3,440	$0
NON-FFS SUBTOTAL	**$2,799,364,800**	**$174,194,570**	**$10,056,803,250**	**$2,456,528,300**	**$809,546,190**	**$2,447,720**
TOTAL DOLLARS (1)	**$3,699,910,400**	**$266,524,710**	**$13,339,028,640**	**$3,203,327,540**	**$2,931,883,480**	**$14,816,400**
ELIGIBLES ***	**420,000**	**21,400**	**1,000,200**	**1,408,400**	**45,900**	**200**
ANNUAL $/ELIGIBLE	**$8,809**	**$12,454**	**$13,336**	**$2,274**	**$63,875**	**$74,082**
AVG. MO. $/ELIGIBLE	**$734**	**$1,038**	**$1,111**	**$190**	**$5,323**	**$6,173**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-AB	MN-ATD	MN-AFDC
PHYSICIANS	$9,778,890	$21,083,420	$33,101,510	$463,760	$72,142,690	$326,022,000
OTHER MEDICAL	$8,009,850	$108,454,510	$86,163,920	$1,072,480	$124,132,340	$835,146,120
COUNTY OUTPATIENT	$424,380	$808,620	$1,256,930	$25,060	$7,122,560	$20,483,140
COMMUNITY OUTPATIENT	$1,188,470	$19,505,450	$9,923,630	$73,070	$34,064,900	$127,871,120
PHARMACY	$5,947,600	$59,848,230	$7,345,250	$110,980	$42,051,230	$90,601,520
COUNTY INPATIENT	$16,063,540	$4,711,460	$16,170,390	$883,880	$136,989,380	$183,770,430
COMMUNITY INPATIENT	$47,868,670	$80,823,600	$90,742,770	$1,748,790	$465,116,960	$1,305,673,130
NURSING FACILITIES	$580,565,560	$486,730	$260,644,890	$816,390	$89,857,690	$19,396,210
ICF-DD	$162,476,810	$126,720	$710,840	$0	$8,652,240	$283,690
MEDICAL TRANSPORTATION	$3,138,760	$809,010	$15,389,540	$224,810	$22,446,500	$14,327,260
OTHER SERVICES	$16,222,870	$24,382,780	$36,416,850	$116,410	$39,945,100	$95,116,240
HOME HEALTH	$54,230	$4,583,490	$501,660	$14,270	$60,658,700	$10,330,810
FFS SUBTOTAL	**$851,739,630**	**$325,624,030**	**$558,368,170**	**$5,549,880**	**$1,103,180,290**	**$3,029,021,660**
DENTAL	$945,970	$47,191,650	$19,503,540	$36,380	$11,143,460	$228,362,610
TWO PLAN MODEL	-$209,220	$559,414,630	$575,125,810	$2,070,810	$357,166,840	$3,272,190,270
COUNTY ORGANIZED HEALTH SYSTEMS	$229,261,290	$220,929,240	$234,841,170	$464,448,270	$265,883,700	$990,590,750
GEOGRAPHIC MANAGED CARE	-$36,070	$111,161,520	$62,341,630	$75,220	$52,356,900	$462,327,760
PHP & OTHER MANAG. CARE	$161,960	$19,386,860	$81,409,430	$113,970	$9,202,960	$107,476,560
EPSDT SCREENS	$0	$5,313,170	$0	$0	$0	$20,514,090
MEDICARE PAYMENTS	$36,619,000	$0	$705,059,360	$0	$355,561,200	$69,729,190
STATE HOSP./DEVELOPMENTAL CNTRS.	$186,230,980	$0	$26,100	$26,100	$234,880	$130,490
MISC. SERVICES	$1,100	$0	$484,636,480	$936,910	$560,562,750	$2,051,430
NON-FFS SUBTOTAL	**$452,975,000**	**$963,397,070**	**$2,162,943,520**	**$467,707,650**	**$1,612,112,680**	**$5,153,373,140**
TOTAL DOLLARS (1)	**$1,304,714,640**	**$1,289,021,100**	**$2,721,311,690**	**$473,257,530**	**$2,715,292,980**	**$8,182,394,800**
ELIGIBLES ***	**14,700**	**894,800**	**315,600**	**600**	**180,500**	**3,592,900**
ANNUAL $/ELIGIBLE	**$88,756**	**$1,441**	**$8,623**	**$788,763**	**$15,043**	**$2,277**
AVG. MO. $/ELIGIBLE	**$7,396**	**$120**	**$719**	**$65,730**	**$1,254**	**$190**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	MI-C	MI-A	REFUGEE	OBRA	POV 185	POV 133
PHYSICIANS	$44,883,040	$38,299,580	$298,180	$29,225,740	$238,186,630	$4,900,470
OTHER MEDICAL	$130,682,650	$76,618,020	$1,999,180	$46,136,730	$246,074,510	$41,161,580
COUNTY OUTPATIENT	$1,991,440	$2,792,840	$83,570	$5,535,040	$3,718,030	$159,800
COMMUNITY OUTPATIENT	$18,380,890	$10,673,220	$123,050	$7,523,560	$31,236,230	$2,930,410
PHARMACY	$32,160,010	$113,437,480	$458,150	$8,153,960	$8,040,970	$1,662,220
COUNTY INPATIENT	$13,800,620	$19,693,550	$54,950	$43,393,300	$56,606,120	$590,020
COMMUNITY INPATIENT	$125,775,020	$145,222,010	$513,510	$105,663,020	$513,305,540	$14,283,160
NURSING FACILITIES	$6,607,130	$36,405,490	$117,170	$22,058,660	$126,870	$408,150
ICF-DD	$1,511,130	$673,480	$0	$272,960	$0	$0
MEDICAL TRANSPORTATION	$2,363,760	$6,348,530	$11,870	$5,008,960	$1,967,060	$176,500
OTHER SERVICES	$24,288,160	$16,694,790	$18,970	$2,657,750	$13,663,500	$11,777,450
HOME HEALTH	$12,731,330	$65,460	$2,020	$13,370	$1,536,650	$1,163,360
FFS SUBTOTAL	**$415,175,170**	**$466,924,440**	**$3,680,610**	**$275,643,040**	**$1,114,462,110**	**$79,213,120**
DENTAL	$16,776,410	$8,821,180	$157,460	$163,310	$619,680	$10,755,150
TWO PLAN MODEL	$62,993,810	$1,485,664,140	$1,246,170	$0	$62,065,440	$167,626,410
COUNTY ORGANIZED HEALTH SYSTEMS	$41,848,590	$637,199,880	$265,900	$3,839,790	$27,048,740	$68,698,660
GEOGRAPHIC MANAGED CARE	$11,966,200	$235,737,700	$520,480	$0	$13,511,690	$40,867,170
PHP & OTHER MANAG. CARE	$1,972,840	$0	$0	$0	$2,130,480	$4,861,120
EPSDT SCREENS	$1,499,780	$0	$0	$0	$0	$1,009,140
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$443,360	$26,100	$0	$234,880	$78,290	$0
MISC. SERVICES	$5,334,300	$34,033,130	$0	$0	$73,030	$162,550
NON-FFS SUBTOTAL	**$142,835,300**	**$2,401,482,120**	**$2,190,010**	**$4,237,970**	**$105,527,350**	**$293,980,200**
TOTAL DOLLARS (1)	**$558,010,460**	**$2,868,406,560**	**$5,870,620**	**$279,881,020**	**$1,219,989,460**	**$373,193,320**
ELIGIBLES ***	**249,500**	**527,000**	**2,400**	**88,800**	**196,100**	**176,200**
ANNUAL $/ELIGIBLE	**$2,237**	**$5,443**	**$2,446**	**$3,152**	**$6,221**	**$2,118**
AVG. MO. $/ELIGIBLE	**$186**	**$454**	**$204**	**$263**	**$518**	**$177**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	POV 100	TOTAL
PHYSICIANS	$6,350,460	**$1,134,131,500**
OTHER MEDICAL	$33,685,460	**$2,552,020,540**
COUNTY OUTPATIENT	$334,090	**$54,402,230**
COMMUNITY OUTPATIENT	$4,463,100	**$468,947,380**
PHARMACY	$5,153,140	**$745,995,390**
COUNTY INPATIENT	$2,199,720	**$579,260,030**
COMMUNITY INPATIENT	$21,369,680	**$4,155,043,580**
NURSING FACILITIES	$487,430	**$4,342,974,500**
ICF-DD	$11,660	**$385,761,820**
MEDICAL TRANSPORTATION	$267,320	**$157,142,360**
OTHER SERVICES	$6,290,710	**$642,117,420**
HOME HEALTH	$1,624,610	**$249,629,160**
FFS SUBTOTAL	**$82,237,390**	**$15,467,425,900**
DENTAL	$13,001,160	**$541,155,750**
TWO PLAN MODEL	$208,923,790	**$12,528,387,100**
COUNTY ORGANIZED HEALTH SYSTEMS	$70,459,770	**$5,685,065,240**
GEOGRAPHIC MANAGED CARE	$51,586,150	**$2,044,527,770**
PHP & OTHER MANAG. CARE	$5,529,600	**$448,475,870**
EPSDT SCREENS	$1,282,680	**$37,965,360**
MEDICARE PAYMENTS	$0	**$3,967,162,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	$260,970	**$261,025,800**
MISC. SERVICES	$56,390	**$4,898,982,460**
NON-FFS SUBTOTAL	**$351,100,510**	**$30,412,747,350**
TOTAL DOLLARS (1)	**$433,337,900**	**$45,880,173,250**
ELIGIBLES ***	**223,000**	**9,358,200**
ANNUAL $/ELIGIBLE	**$1,943**	**$4,903**
AVG. MO. $/ELIGIBLE	**$162**	**$409**

(1) Does not include Audits & Lawsuits, Recoveries, and Mental Health Services.
*** Eligibles include the estimated impact of eligibility policy changes.

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 71

2	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
49	SCHIP FUNDING FOR PRENATAL CARE
51	WOMEN'S HEALTH SERVICES
54	NON FFP DRUGS
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 PI
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

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 71

106	MH/UCD & BTR—BCCTP
107	MH/UCD & BTR—DPH INTERIM RATE
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNI
123	CCI-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 PAYMENTS
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
180	MEDI-CAL TCM PROGRAM
184	CDDS DENTAL SERVICES
187	AUDIT SETTLEMENTS

FISCAL YEAR 2013-14 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 71

192	CIGARETTE AND TOBACCO SURTAX FUNDS
194	CLPP FUND
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE
197	CCI-TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
212	AIM LINKED MOTHERS 200-300% FPL
217	ACA MAGI SAVINGS

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2014-15

	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
I. BASE ESTIMATES			
A. B/Y FFS BASE	$16,131,330,220	$8,065,665,110	$8,065,665,110
B. B/Y BASE POLICY CHANGES	$26,592,467,010	$15,984,950,000	$10,607,517,000
C. BASE ADJUSTMENTS	-$129,970,000	-$107,875,500	-$22,094,500
D. ADJUSTED BASE	$42,593,827,230	$23,942,739,620	$18,651,087,610
II. REGULAR POLICY CHANGES			
A. ELIGIBILITY	$936,411,960	$681,847,080	$254,564,880
B. AFFORDABLE CARE ACT	$17,544,315,510	$16,476,676,320	$1,067,639,190
C. BENEFITS	$855,197,210	$809,830,940	$45,366,270
D. PHARMACY	-$1,803,890,580	-$1,024,690,790	-$779,199,790
E. DRUG MEDI-CAL	$429,000	$677,000	-$248,000
F. MENTAL HEALTH	$528,328,000	$522,328,000	$6,000,000
G. WAIVER--MH/UCD & BTR	$9,164,300,200	$6,199,705,600	$2,964,594,600
H. MANAGED CARE	$7,981,344,000	$2,990,810,000	$4,990,534,000
I. PROVIDER RATES	-$39,413,220	-$19,706,610	-$19,706,610
J. SUPPLEMENTAL PMNTS.	$8,455,766,000	$4,763,405,500	$3,692,360,500
K. OTHER	$150,140,000	$99,160,000	$50,980,000
L. TOTAL CHANGE	$43,772,928,080	$31,500,043,040	$12,272,885,040
III. TOTAL MEDI-CAL ESTIMATE	**$86,366,755,320**	**$55,442,782,660**	**$30,923,972,660**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	ELIGIBILITY			
2	FAMILY PACT PROGRAM	$587,160,000	$440,095,500	$147,064,500
3	BREAST AND CERVICAL CANCER TREATMENT	$159,874,000	$89,934,000	$69,940,000
4	AIM LINKED INFANTS 250-300% FPL	$33,232,000	$21,600,800	$11,631,200
5	MEDI-CAL ADULT INMATE PROGRAMS	$27,477,000	$27,477,000	$0
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM/	$5,469,000	$5,469,000	$0
8	REFUGEES	$5,844,000	$0	$5,844,000
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$1,726,000	$1,122,000	$604,000
11	NEW QUALIFIED IMMIGRANTS	$0	-$63,324,000	$63,324,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	$86,018,250	-$86,018,250
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$8,949,550	-$8,949,550
14	INCARCERATION VERIFICATION PROGRAM	-$417,140	-$208,570	-$208,570
15	PARIS-FEDERAL	-$3,611,490	-$1,805,750	-$1,805,750
16	PARIS-VETERANS	-$1,468,370	-$734,190	-$734,190
17	PARIS-INTERSTATE	-$5,045,030	-$2,522,510	-$2,522,510
212	AIM LINKED MOTHERS 200-300% FPL	$126,172,000	$69,776,000	$56,396,000
	ELIGIBILITY SUBTOTAL	**$936,411,960**	**$681,847,080**	**$254,564,880**
	AFFORDABLE CARE ACT			
18	ACA OPTIONAL EXPANSION	$12,553,609,000	$12,547,326,000	$6,283,000
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	$745,128,630	$721,663,380	$23,465,250
20	COMMUNITY FIRST CHOICE OPTION	$228,504,000	$228,504,000	$0
21	ACA MANDATORY EXPANSION	$1,993,963,000	$1,064,057,650	$929,905,350
22	MENTAL HEALTH SERVICES EXPANSION	$391,459,000	$252,874,050	$138,584,950
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COS	$67,870,000	$67,870,000	$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$98,079,000	$79,133,750	$18,945,250
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$56,924,000	$36,286,000	$20,638,000
27	USPSTF GRADE A AND B RECOMMENDATIONS	$89,624,500	$60,809,550	$28,814,950
28	ACA DELAY OF REDETERMINATIONS	$53,303,000	$27,291,300	$26,011,700
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	-$115,000	$115,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$39,582,000	-$39,582,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-$76,610	-$38,310	-$38,310
34	MANAGED CARE DRUG REBATES	-$330,400,000	-$165,200,000	-$165,200,000
205	HEALTH INSURER FEE	$121,306,000	$66,718,500	$54,587,500
206	ACA EXPRESS LANE ENROLLMENT	$1,508,167,000	$1,448,743,950	$59,423,050
210	ACA EXPANSION-PREGNANCY ONLY	-$33,145,000	-$16,572,500	-$16,572,500
217	ACA MAGI SAVINGS	$0	$17,742,000	-$17,742,000
	AFFORDABLE CARE ACT SUBTOTAL	**$17,544,315,520**	**$16,476,676,320**	**$1,067,639,190**
	BENEFITS			

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
	BENEFITS			
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$312,967,000	$312,967,000	$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$144,536,000	$144,536,000	$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$26,085,000	$23,266,000	$2,819,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFIT	$311,879,000	$201,931,000	$109,948,000
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	$0	$0	$0
43	CCT FUND TRANSFER TO CDSS AND CDDS	$3,912,000	$3,912,000	$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$270,000
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$516,000	$516,000	$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$150,000	$150,000	$0
49	SCHIP FUNDING FOR PRENATAL CARE	$0	$92,502,800	-$92,502,800
50	COPAYMENT FOR NON-EMERGENCY ER VISITS	-$33,707,000	-$16,853,500	-$16,853,500
51	WOMEN'S HEALTH SERVICES	-$17,154,480	-$13,508,330	-$3,646,150
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$20,218,000	-$10,109,000	-$10,109,000
66	VOLUNTARY INPATIENT DETOXIFICATION	$27,076,690	$17,132,970	$9,943,720
208	DENTAL CHILDREN'S OUTREACH AGES 0-3	$17,636,000	$9,490,000	$8,146,000
	BENEFITS SUBTOTAL	**$855,197,210**	**$809,830,940**	**$45,366,280**
	PHARMACY			
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	$28,646,420	$14,323,210	$14,323,210
54	NON FFP DRUGS	$0	-$2,106,000	$2,106,000
55	BCCTP DRUG REBATES	-$15,764,000	-$10,246,600	-$5,517,400
56	MEDICAL SUPPLY REBATES	-$24,428,000	-$12,214,000	-$12,214,000
57	FAMILY PACT DRUG REBATES	-$73,085,000	-$63,727,300	-$9,357,700
59	AGED AND DISPUTED DRUG REBATES	-$196,000,000	-$98,018,000	-$97,982,000
60	STATE SUPPLEMENTAL DRUG REBATES	-$161,296,000	-$82,137,200	-$79,158,800
61	FEDERAL DRUG REBATE PROGRAM	-$1,299,000,000	-$739,082,900	-$559,917,100
211	MCO SUPPLEMENTAL DRUG REBATE	-$65,000,000	-$32,500,000	-$32,500,000
219	VISION OUTREACH	$2,036,000	$1,018,000	$1,018,000
	PHARMACY SUBTOTAL	**-$1,803,890,580**	**-$1,024,690,790**	**-$779,199,790**
	DRUG MEDI-CAL			
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$3,036,000	$0
68	ANNUAL RATE ADJUSTMENT	-$2,607,000	-$2,359,000	-$248,000
	DRUG MEDI-CAL SUBTOTAL	**$429,000**	**$677,000**	**-$248,000**
	MENTAL HEALTH			

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
	MENTAL HEALTH			
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	$353,018,000	$353,018,000	$0
72	ELIMINATION OF STATE MAXIMUM RATES	$72,161,000	$72,161,000	$0
73	TRANSITION OF HFP - SMH SERVICES	$41,848,000	$41,848,000	$0
74	KATIE A. V. DIANA BONTA	$26,751,000	$26,751,000	$0
75	HEALTHY FAMILIES - SED	$7,070,000	$7,070,000	$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	$0	$0	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAY	$0	$0	$0
80	IMD ANCILLARY SERVICES	$0	-$6,000,000	$6,000,000
81	CHART REVIEW	-$320,000	-$320,000	$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$0	$0	$0
	MENTAL HEALTH SUBTOTAL	**$528,328,000**	**$522,328,000**	**$6,000,000**
	WAIVER--MH/UCD & BTR			
84	BTR - LIHP - MCE	$4,210,969,000	$2,225,963,000	$1,985,006,000
85	MH/UCD & BTR—DSH PAYMENT	$1,762,250,000	$1,169,817,000	$592,433,000
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	$1,152,624,000	$576,312,000	$576,312,000
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEM	$551,013,000	$275,506,500	$275,506,500
88	BTR—SAFETY NET CARE POOL	$242,250,000	$242,250,000	$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	$268,001,000	$134,000,500	$134,000,500
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$21,373,000	$21,373,000	$0
91	MH/UCD & BTR—CCS AND GHPP	$117,158,000	$117,158,000	$0
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SV	$275,629,000	$139,943,000	$135,686,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$85,000,000	$85,000,000	$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	$53,645,000	$340,094,000	-$286,449,000
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$20,369,360	$10,184,680	$10,184,680
98	BTR—INCREASE SAFETY NET CARE POOL	$6,500,000	$6,500,000	$0
99	MH/UCD—STABILIZATION FUNDING	$41,378,000	$11,750,000	$29,628,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$435,143,000	$435,143,000	$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HE	$2,370,000	$2,370,000	$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$4,712,000	$2,356,000	$2,356,000
104	MH/UCD—SAFETY NET CARE POOL	$46,752,000	$46,752,000	$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	$392,395,000	-$392,395,000
108	BTR—INCREASE DESIGNATED STATE HEALTH PROG	$0	$6,500,000	-$6,500,000
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	$8,959,000	-$8,959,000

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
	WAIVER--MH/UCD & BTR			
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOV	-$13,000,000	-$13,000,000	$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLO	-$119,836,160	-$59,918,080	-$59,918,080
	WAIVER--MH/UCD & BTR SUBTOTAL	**$9,164,300,200**	**$6,199,705,600**	**$2,964,594,600**
	MANAGED CARE			
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,481,657,000	$959,960,000	$521,697,000
118	MANAGED CARE RATE RANGE IGTS	$860,767,000	$460,729,000	$400,038,000
119	CCI-MANAGED CARE PAYMENTS	$6,901,009,000	$3,450,504,500	$3,450,504,500
120	MANAGED CARE PUBLIC HOSPITAL IGTS	$431,688,000	$215,844,000	$215,844,000
123	CCI-TRANSFER OF IHSS COSTS TO CDSS	$2,496,678,000	$0	$2,496,678,000
124	RETRO MC RATE ADJUSTMENTS	$337,849,000	$168,924,500	$168,924,500
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	-$26,934,000	-$13,467,000	-$13,467,000
131	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$0	$2,000,000
132	CAPITATED RATE ADJUSTMENT FOR FY 2014-15	$0	$0	$0
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
142	DISCONTINUE UNDOCUMENTED BENEFICIARIES FR	-$1,071,000	-$535,500	-$535,500
143	CCI-SAVINGS AND DEFERRAL	-$4,502,299,000	-$2,251,149,500	-$2,251,149,500
	MANAGED CARE SUBTOTAL	**$7,981,344,000**	**$2,990,810,000**	**$4,990,534,000**
	PROVIDER RATES			
24	AB 1629 ADD-ONS	$38,764,880	$19,382,440	$19,382,440
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	$188,409,910	$94,204,960	$94,204,960
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$125,322,250	$62,661,130	$62,661,130
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	$90,068,000	$45,034,000	$45,034,000
147	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$30,000,000	$15,000,000	$15,000,000
148	LTC RATE ADJUSTMENT	$17,702,280	$8,851,140	$8,851,140
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$13,761,030	$6,880,510	$6,880,510
150	HOSPICE RATE INCREASES	$7,907,810	$3,953,910	$3,953,910
151	LONG TERM CARE QUALITY ASSURANCE FUND EXP	$0	$0	$0
152	NON-AB 1629 LTC RATE FREEZE	-$26,288,850	-$13,144,430	-$13,144,420
153	DENTAL RETROACTIVE RATE CHANGES	-$4,485,000	-$2,242,500	-$2,242,500
154	LABORATORY RATE METHODOLOGY CHANGE	-$10,900,700	-$5,450,350	-$5,450,350
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$29,549,710	-$14,774,860	-$14,774,860
156	REDUCTION TO RADIOLOGY RATES	-$32,891,820	-$16,445,910	-$16,445,910

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
	PROVIDER RATES			
157	10% PROVIDER PAYMENT REDUCTION	-$454,852,300	-$227,426,150	-$227,426,150
214	GENETIC DISEASE SCREENING PROGRAM FEE INCF	$7,619,000	$3,809,500	$3,809,500
	PROVIDER RATES SUBTOTAL	**-$39,413,220**	**-$19,706,610**	**-$19,706,610**
	SUPPLEMENTAL PMNTS.			
158	HOSPITAL QAF - HOSPITAL PAYMENTS	$740,311,000	$323,789,000	$416,522,000
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$6,945,877,000	$3,820,000,000	$3,125,877,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	$183,000,000	$183,000,000	$0
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$20,000,000	$20,000,000	$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$197,287,000	$197,287,000	$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	$70,000,000	$35,000,000	$35,000,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	$46,235,000	$46,235,000	$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	$146,731,000	$83,269,500	$63,461,500
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	$3,325,000	$3,325,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$8,455,766,000**	**$4,763,405,500**	**$3,692,360,500**
	OTHER			
177	ARRA HITECH - PROVIDER PAYMENTS	$149,720,000	$149,720,000	$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- (	$107,104,000	$107,104,000	$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	$61,544,000	$30,772,000	$30,772,000
184	CDDS DENTAL SERVICES	$11,972,000	$0	$11,972,000
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDD	$16,415,000	$9,934,000	$6,481,000
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$3,919,000	$2,743,000	$1,176,000
187	AUDIT SETTLEMENTS	$9,910,000	$0	$9,910,000
191	INDIAN HEALTH SERVICES	$2,180,000	$11,615,500	-$9,435,500
192	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0
194	CLPP FUND	$0	$0	$0
197	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0
201	IHSS REDUCTION IN SERVICE HOURS	-$212,833,000	-$212,833,000	$0
216	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$209,000	$104,500	$104,500
	OTHER SUBTOTAL	**$150,140,000**	**$99,160,000**	**$50,980,000**
	GRAND TOTAL	**$43,772,928,090**	**$31,500,043,040**	**$12,272,885,050**

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

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

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
PROFESSIONAL	$8,019,037,110	$5,409,328,390	$2,609,708,720
PHYSICIANS	$1,311,310,410	$930,939,480	$380,370,930
OTHER MEDICAL	$4,438,245,880	$3,133,837,290	$1,304,408,590
COUNTY OUTPATIENT	$149,219,610	$122,589,730	$26,629,880
COMMUNITY OUTPATIENT	$2,120,261,220	$1,221,961,900	$898,299,320
PHARMACY	$1,052,068,420	$722,456,980	$329,611,440
HOSPITAL INPATIENT	$13,315,628,050	$8,429,696,520	$4,885,931,530
COUNTY INPATIENT	$2,664,208,460	$2,098,245,500	$565,962,960
COMMUNITY INPATIENT	$10,651,419,580	$6,331,451,020	$4,319,968,570
LONG TERM CARE	$3,318,276,140	$1,689,097,270	$1,629,178,870
NURSING FACILITIES	$3,079,591,210	$1,566,721,640	$1,512,869,560
ICF-DD	$238,684,940	$122,375,630	$116,309,310
OTHER SERVICES	$935,155,190	$532,821,550	$402,333,630
MEDICAL TRANSPORTATION	$162,431,540	$101,749,460	$60,682,080
OTHER SERVICES	$570,331,740	$319,982,980	$250,348,760
HOME HEALTH	$202,391,910	$111,089,110	$91,302,800
TOTAL FEE-FOR-SERVICE	**$26,640,164,910**	**$16,783,400,720**	**$9,856,764,190**
MANAGED CARE	$40,887,515,920	$25,404,415,080	$15,483,100,850
TWO PLAN MODEL	$26,025,293,680	$16,153,674,510	$9,871,619,170
COUNTY ORGANIZED HEALTH SYS	$9,635,190,910	$6,109,006,420	$3,526,184,490
GEOGRAPHIC MANAGED CARE	$4,300,719,280	$2,664,982,540	$1,635,736,740
PHP & OTHER MANAG. CARE	$926,312,050	$476,751,600	$449,560,450
DENTAL	$947,437,230	$556,528,370	$390,908,860
MENTAL HEALTH	$2,434,957,490	$2,391,024,480	$43,933,010
AUDITS/ LAWSUITS	$20,358,240	$4,259,380	$16,098,860
EPSDT SCREENS	$37,505,900	$19,988,680	$17,517,220
MEDICARE PAYMENTS	$4,037,746,000	$1,202,258,500	$2,835,487,500
STATE HOSP./DEVELOPMENTAL CNTRS.	$267,389,730	$267,367,570	$22,160
MISC. SERVICES	$11,359,964,890	$8,945,792,890	$2,414,172,000
RECOVERIES	-$266,285,000	-$132,253,000	-$134,032,000
GRAND TOTAL MEDI-CAL	**$86,366,755,320**	**$55,442,782,660**	**$30,923,972,660**

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

SERVICE CATEGORY	MAY 2014 EST. FOR 2013-14	MAY 2014 EST. FOR 2014-15	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$5,558,911,710	$8,019,037,110	$2,460,125,410	44.26
PHYSICIANS	$1,335,191,310	$1,311,310,410	-$23,880,900	-1.79
OTHER MEDICAL	$2,974,871,250	$4,438,245,880	$1,463,374,630	49.19
COUNTY OUTPATIENT	$133,515,020	$149,219,610	$15,704,590	11.76
COMMUNITY OUTPATIENT	$1,115,334,130	$2,120,261,220	$1,004,927,090	90.10
PHARMACY	$871,818,940	$1,052,068,420	$180,249,490	20.68
HOSPITAL INPATIENT	$10,057,720,010	$13,315,628,050	$3,257,908,030	32.39
COUNTY INPATIENT	$2,163,420,760	$2,664,208,460	$500,787,710	23.15
COMMUNITY INPATIENT	$7,894,299,260	$10,651,419,580	$2,757,120,330	34.93
LONG TERM CARE	$4,977,840,970	$3,318,276,140	-$1,659,564,830	-33.34
NURSING FACILITIES	$4,585,171,550	$3,079,591,210	-$1,505,580,350	-32.84
ICF-DD	$392,669,410	$238,684,940	-$153,984,480	-39.21
OTHER SERVICES	$1,160,267,380	$935,155,190	-$225,112,190	-19.40
MEDICAL TRANSPORTATION	$260,297,240	$162,431,540	-$97,865,700	-37.60
OTHER SERVICES	$645,243,080	$570,331,740	-$74,911,340	-11.61
HOME HEALTH	$254,727,050	$202,391,910	-$52,335,150	-20.55
TOTAL FEE-FOR-SERVICE	**$22,626,559,010**	**$26,640,164,910**	**$4,013,605,900**	**17.74**
MANAGED CARE	$22,188,338,980	$40,887,515,920	$18,699,176,950	84.27
TWO PLAN MODEL	$13,414,476,690	$26,025,293,680	$12,610,816,990	94.01
COUNTY ORGANIZED HEALTH SYSTEMS	$6,095,838,250	$9,635,190,910	$3,539,352,660	58.06
GEOGRAPHIC MANAGED CARE	$2,194,553,170	$4,300,719,280	$2,106,166,110	95.97
PHP & OTHER MANAG. CARE	$483,470,870	$926,312,050	$442,841,190	91.60
DENTAL	$553,127,750	$947,437,230	$394,309,480	71.29
MENTAL HEALTH	$1,668,432,240	$2,434,957,490	$766,525,260	45.94
AUDITS/ LAWSUITS	-$75,434,780	$20,358,240	$95,793,020	-126.99
EPSDT SCREENS	$37,965,360	$37,505,900	-$459,460	-1.21
MEDICARE PAYMENTS	$3,967,162,000	$4,037,746,000	$70,584,000	1.78
STATE HOSP./DEVELOPMENTAL CNTRS.	$266,006,860	$267,389,730	$1,382,880	0.52
MISC. SERVICES	$7,745,799,460	$11,359,964,890	$3,614,165,430	46.66
RECOVERIES	-$312,935,000	-$266,285,000	$46,650,000	-14.91
GRAND TOTAL MEDI-CAL	**$58,665,021,860**	**$86,366,755,320**	**$27,701,733,450**	**47.22**
STATE FUNDS	**$21,802,906,170**	**$30,923,972,660**	**$9,121,066,490**	**41.83**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

SERVICE CATEGORY	NOV. 2013 EST. FOR 2014-15	MAY 2014 EST. FOR 2014-15	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$6,272,051,330	$8,019,037,110	$1,746,985,780	27.85
PHYSICIANS	$1,135,237,760	$1,311,310,410	$176,072,650	15.51
OTHER MEDICAL	$3,339,772,300	$4,438,245,880	$1,098,473,580	32.89
COUNTY OUTPATIENT	$146,378,330	$149,219,610	$2,841,270	1.94
COMMUNITY OUTPATIENT	$1,650,662,940	$2,120,261,220	$469,598,280	28.45
PHARMACY	$585,242,620	$1,052,068,420	$466,825,800	79.77
HOSPITAL INPATIENT	$10,546,984,350	$13,315,628,050	$2,768,643,690	26.25
COUNTY INPATIENT	$2,309,793,940	$2,664,208,460	$354,414,520	15.34
COMMUNITY INPATIENT	$8,237,190,410	$10,651,419,580	$2,414,229,170	29.31
LONG TERM CARE	$3,469,473,320	$3,318,276,140	-$151,197,180	-4.36
NURSING FACILITIES	$3,230,262,200	$3,079,591,210	-$150,670,990	-4.66
ICF-DD	$239,211,120	$238,684,940	-$526,190	-0.22
OTHER SERVICES	$827,094,470	$935,155,190	$108,060,710	13.07
MEDICAL TRANSPORTATION	$183,217,080	$162,431,540	-$20,785,540	-11.34
OTHER SERVICES	$444,256,420	$570,331,740	$126,075,320	28.38
HOME HEALTH	$199,620,970	$202,391,910	$2,770,940	1.39
TOTAL FEE-FOR-SERVICE	**$21,700,846,100**	**$26,640,164,910**	**$4,939,318,810**	**22.76**
MANAGED CARE	$34,013,370,910	$40,887,515,920	$6,874,145,010	20.21
TWO PLAN MODEL	$21,568,025,340	$26,025,293,680	$4,457,268,340	20.67
COUNTY ORGANIZED HEALTH SYSTEMS	$8,243,429,040	$9,635,190,910	$1,391,761,870	16.88
GEOGRAPHIC MANAGED CARE	$3,427,710,390	$4,300,719,280	$873,008,890	25.47
PHP & OTHER MANAG. CARE	$774,206,140	$926,312,050	$152,105,910	19.65
DENTAL	$892,390,710	$947,437,230	$55,046,520	6.17
MENTAL HEALTH	$1,929,833,090	$2,434,957,490	$505,124,410	26.17
AUDITS/ LAWSUITS	$4,565,870	$20,358,240	$15,792,370	345.88
EPSDT SCREENS	$36,969,910	$37,505,900	$535,990	1.45
MEDICARE PAYMENTS	$4,155,206,000	$4,037,746,000	-$117,460,000	-2.83
STATE HOSP./DEVELOPMENTAL CNTRS.	$265,354,240	$267,389,730	$2,035,500	0.77
MISC. SERVICES	$6,981,973,590	$11,359,964,890	$4,377,991,310	62.70
RECOVERIES	-$255,248,000	-$266,285,000	-$11,037,000	4.32
GRAND TOTAL MEDI-CAL	**$69,725,262,400**	**$86,366,755,320**	**$16,641,492,910**	**23.87**
STATE FUNDS	**$26,948,837,770**	**$30,923,972,660**	**$3,975,134,890**	**14.75**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	ELIGIBILITY						
1	TRANSITION OF HFP TO MEDI-CAL	$1,266,927,000	$443,424,450	$0	$0	-$1,266,927,000	-$443,424,450
2	FAMILY PACT PROGRAM	$656,141,000	$164,342,100	$587,160,000	$147,064,500	-$68,981,000	-$17,277,600
3	BREAST AND CERVICAL CANCER TREATMENT	$163,528,000	$71,429,650	$159,874,000	$69,940,000	-$3,654,000	-$1,489,650
4	AIM LINKED INFANTS 250-300% FPL	$33,357,000	$11,674,950	$33,232,000	$11,631,200	-$125,000	-$43,750
5	MEDI-CAL ADULT INMATE PROGRAMS	$10,827,000	$0	$27,477,000	$0	$16,650,000	$0
6	CHDP GATEWAY - PREENROLLMENT	$12,786,000	$4,475,100	$0	$0	-$12,786,000	-$4,475,100
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	$5,517,000	$0	$5,469,000	$0	-$48,000	$0
8	REFUGEES	$6,475,000	$6,475,000	$5,844,000	$5,844,000	-$631,000	-$631,000
9	MCHA VS. DHCS AND MRMIB	$234,000	$117,000	$0	$0	-$234,000	-$117,000
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$2,409,000	$933,000	$1,726,000	$604,000	-$683,000	-$329,000
11	NEW QUALIFIED IMMIGRANTS	$0	$63,554,000	$0	$63,324,000	$0	-$230,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	-$57,988,650	$0	-$86,018,250	$0	-$28,029,600
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	-$8,901,500	$0	-$8,949,550	$0	-$48,050
14	INCARCERATION VERIFICATION PROGRAM	-$348,000	-$174,000	-$573,000	-$286,500	-$225,000	-$112,500
15	PARIS-FEDERAL	-$10,725,000	-$5,362,500	-$15,826,000	-$7,913,000	-$5,101,000	-$2,550,500
16	PARIS-VETERANS	-$3,547,820	-$1,773,910	-$4,041,760	-$2,020,880	-$493,940	-$246,970
17	PARIS-INTERSTATE	-$38,477,000	-$19,238,500	-$32,216,000	-$16,108,000	$6,261,000	$3,130,500
212	AIM LINKED MOTHERS 200-300% FPL	$128,655,000	$57,459,000	$126,172,000	$56,396,000	-$2,483,000	-$1,063,000
	ELIGIBILITY SUBTOTAL	**$2,233,758,180**	**$730,445,190**	**$894,297,240**	**$233,507,520**	**-$1,339,460,940**	**-$496,937,670**
	AFFORDABLE CARE ACT						
18	ACA OPTIONAL EXPANSION	$6,586,221,000	$0	$12,553,609,000	$6,283,000	$5,967,388,000	$6,283,000
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	$602,426,830	$27,210,580	$745,128,630	$23,465,250	$142,701,800	-$3,745,330
20	COMMUNITY FIRST CHOICE OPTION	$219,412,000	$0	$228,504,000	$0	$9,092,000	$0
21	ACA MANDATORY EXPANSION	$867,333,000	$419,214,950	$1,993,963,000	$929,905,350	$1,126,630,000	$510,690,400
22	MENTAL HEALTH SERVICES EXPANSION	$300,000,000	$119,000,000	$391,459,000	$138,584,950	$91,459,000	$19,584,950

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	AFFORDABLE CARE ACT						
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	$49,922,000	$0	$67,870,000	$0	$17,948,000	$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$78,784,000	$37,749,500	$98,079,000	$18,945,250	$19,295,000	-$18,804,250
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$56,924,000	$20,638,000	$56,924,000	$20,638,000	$0	$0
27	USPSTF GRADE A AND B RECOMMENDATIONS	$70,186,000	$26,380,500	$90,749,790	$29,176,740	$20,563,790	$2,796,240
28	ACA DELAY OF REDETERMINATIONS	$668,000	$205,800	$53,303,000	$26,011,700	$52,635,000	$25,805,900
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	$0	$0	$115,000	$0	$115,000
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	-$26,950,000	$0	-$39,582,000	$0	-$12,632,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-$98,220	-$49,110	-$76,610	-$38,310	$21,610	$10,810
32	PRIVATE DSH REPLACEMENT PAYMENT REDUCTION	-$17,113,000	-$8,556,500	$0	$0	$17,113,000	$8,556,500
33	DISPROPORTIONATE SHARE HOSPITAL REDUCTION	-$47,601,000	-$14,978,000	$0	$0	$47,601,000	$14,978,000
34	MANAGED CARE DRUG REBATES	-$292,429,000	-$146,214,500	-$330,400,000	-$165,200,000	-$37,971,000	-$18,985,500
205	HEALTH INSURER FEE	$121,306,000	$54,587,500	$121,306,000	$54,587,500	$0	$0
206	ACA EXPRESS LANE ENROLLMENT	$687,214,000	$11,586,150	$1,508,167,000	$59,423,050	$820,953,000	$47,836,900
210	ACA EXPANSION-PREGNANCY ONLY	-$33,145,000	-$16,572,500	-$33,145,000	-$16,572,500	$0	$0
217	ACA MAGI SAVINGS	$0	$0	$0	-$17,742,000	$0	-$17,742,000
	AFFORDABLE CARE ACT SUBTOTAL	**$9,250,010,600**	**$503,252,370**	**$17,545,440,810**	**$1,068,000,980**	**$8,295,430,210**	**$564,748,610**
	BENEFITS						
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$256,044,000	$0	$312,967,000	$0	$56,923,000	$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$145,124,000	$0	$144,536,000	$0	-$588,000	$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$24,679,000	$2,707,000	$26,085,000	$2,819,000	$1,406,000	$112,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFITS	$239,531,000	$72,941,000	$311,879,000	$109,948,000	$72,348,000	$37,007,000
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	$34,170,000	$17,085,000	$34,170,000	$17,085,000	$0	$0
41	YOUTH REGIONAL TREATMENT CENTERS	$6,345,000	$34,000	$6,345,000	$34,000	$0	$0
42	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREI	$4,841,000	$2,420,500	$4,841,000	$2,420,500	$0	$0

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	BENEFITS						
43	CCT FUND TRANSFER TO CDSS AND CDDS	$3,415,000	$0	$3,912,000	$0	$497,000	$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$540,000	$270,000	$0	$0
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$501,000	$0	$516,000	$0	$15,000	$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$141,000	$0	$150,000	$0	$9,000	$0
47	INCREASED FEDERAL MATCHING FUNDS FOR FPACT	$0	-$3,794,100	$0	$0	$0	$3,794,100
48	HEARING AID CAP	-$1,434,000	-$717,000	$0	$0	$1,434,000	$717,000
49	SCHIP FUNDING FOR PRENATAL CARE	$0	-$92,051,700	$0	-$92,502,800	$0	-$451,100
50	COPAYMENT FOR NON-EMERGENCY ER VISITS	-$33,707,000	-$16,853,500	-$33,707,000	-$16,853,500	$0	$0
51	WOMEN'S HEALTH SERVICES	-$10,351,000	-$2,374,900	-$20,645,660	-$4,388,190	-$10,294,660	-$2,013,290
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$18,163,000	-$9,081,500	-$20,218,000	-$10,109,000	-$2,055,000	-$1,027,500
66	VOLUNTARY INPATIENT DETOXIFICATION	$23,663,000	$9,940,000	$28,925,000	$10,622,500	$5,262,000	$682,500
208	DENTAL CHILDREN'S OUTREACH AGES 0-3	$17,467,000	$8,098,000	$17,636,000	$8,146,000	$169,000	$48,000
	BENEFITS SUBTOTAL	**$733,270,000**	**$8,854,800**	**$858,395,340**	**$47,723,510**	**$125,125,340**	**$38,868,710**
	PHARMACY						
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	$28,892,000	$14,446,000	$28,646,420	$14,323,210	-$245,580	-$122,790
54	NON FFP DRUGS	$0	$2,077,000	$0	$2,106,000	$0	$29,000
55	BCCTP DRUG REBATES	-$15,764,000	-$5,517,400	-$15,764,000	-$5,517,400	$0	$0
56	MEDICAL SUPPLY REBATES	-$18,321,000	-$9,160,500	-$24,428,000	-$12,214,000	-$6,107,000	-$3,053,500
57	FAMILY PACT DRUG REBATES	-$74,815,000	-$9,579,500	-$73,085,000	-$9,357,700	$1,730,000	$221,800
59	AGED AND DISPUTED DRUG REBATES	-$150,000,000	-$74,611,200	-$196,000,000	-$97,982,000	-$46,000,000	-$23,370,800
60	STATE SUPPLEMENTAL DRUG REBATES	-$180,941,000	-$90,001,300	-$161,296,000	-$79,158,800	$19,645,000	$10,842,500
61	FEDERAL DRUG REBATE PROGRAM	-$1,457,217,000	-$668,831,300	-$1,299,000,000	-$559,917,100	$158,217,000	$108,914,200
211	MCO SUPPLEMENTAL DRUG REBATE	-$65,000,000	-$32,500,000	-$65,000,000	-$32,500,000	$0	$0
219	VISION OUTREACH	$0	$0	$2,036,000	$1,018,000	$2,036,000	$1,018,000
	PHARMACY SUBTOTAL	**-$1,933,166,000**	**-$873,678,200**	**-$1,803,890,580**	**-$779,199,790**	**$129,275,420**	**$94,478,410**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PHARMACY						
	DRUG MEDI-CAL						
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$0	$3,036,000	$0	$0	$0
68	ANNUAL RATE ADJUSTMENT	-$2,607,000	-$248,000	-$2,607,000	-$248,000	$0	$0
	DRUG MEDI-CAL SUBTOTAL	**$429,000**	**-$248,000**	**$429,000**	**-$248,000**	**$0**	**$0**
	MENTAL HEALTH						
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	$107,898,000	$0	$353,018,000	$0	$245,120,000	$0
72	ELIMINATION OF STATE MAXIMUM RATES	$133,477,000	$0	$72,161,000	$0	-$61,316,000	$0
73	TRANSITION OF HFP - SMH SERVICES	$41,938,000	$0	$41,848,000	$0	-$90,000	$0
74	KATIE A. V. DIANA BONTA	$26,751,000	$0	$26,751,000	$0	$0	$0
75	HEALTHY FAMILIES - SED	$18,307,000	$0	$7,070,000	$0	-$11,237,000	$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	$24,800,000	$0	$24,800,000	$0	$0	$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	$0	$0	-$2,270,000	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	$0	$0	$0	$0	$0	$0
80	IMD ANCILLARY SERVICES	$0	$6,000,000	$0	$6,000,000	$0	$0
81	CHART REVIEW	-$418,000	$0	-$320,000	$0	$98,000	$0
82	REIMBURSEMENT IN IMD ANCILLARY SERVICES COST	-$12,000,000	-$12,000,000	$0	$0	$12,000,000	$12,000,000
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$0	$0	$0	$0	$0	$0
	MENTAL HEALTH SUBTOTAL	**$346,023,000**	**-$6,000,000**	**$528,328,000**	**$6,000,000**	**$182,305,000**	**$12,000,000**
	WAIVER--MH/UCD & BTR						
84	BTR - LIHP - MCE	$0	$0	$4,210,969,000	$1,985,006,000	$4,210,969,000	$1,985,006,000
85	MH/UCD & BTR—DSH PAYMENT	$1,702,746,000	$535,885,000	$1,762,250,000	$592,433,000	$59,504,000	$56,548,000

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR						
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE PC	$1,892,310,000	$946,155,000	$1,152,624,000	$576,312,000	-$739,686,000	-$369,843,000
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEME	$534,994,000	$267,497,000	$551,013,000	$275,506,500	$16,019,000	$8,009,500
88	BTR—SAFETY NET CARE POOL	$242,250,000	$0	$242,250,000	$0	$0	$0
89	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL F	$243,001,000	$121,500,500	$268,001,000	$134,000,500	$25,000,000	$12,500,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$0	$0	$21,373,000	$0	$21,373,000	$0
91	MH/UCD & BTR—CCS AND GHPP	$119,676,000	$0	$117,158,000	$0	-$2,518,000	$0
93	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	$0	$0	$275,629,000	$135,686,000	$275,629,000	$135,686,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$82,000,000	$0	$85,000,000	$0	$3,000,000	$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	$53,645,000	-$202,297,000	$53,645,000	-$286,449,000	$0	-$84,152,000
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$108,297,000	$54,148,500	$20,369,360	$10,184,680	-$87,927,640	-$43,963,820
98	BTR—INCREASE SAFETY NET CARE POOL	$0	$0	$6,500,000	$0	$6,500,000	$0
99	MH/UCD—STABILIZATION FUNDING	$7,595,000	$7,595,000	$41,378,000	$29,628,000	$33,783,000	$22,033,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$108,328,000	$0	$435,143,000	$0	$326,815,000	$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	$536,000	$0	$2,370,000	$0	$1,834,000	$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$3,802,000	$1,901,000	$4,712,000	$2,356,000	$910,000	$455,000
104	MH/UCD—SAFETY NET CARE POOL	$35,917,000	$0	$46,752,000	$0	$10,835,000	$0
105	MH/UCD & BTR—MIA-LTC	$0	-$20,118,000	$0	-$20,118,000	$0	$0
106	MH/UCD & BTR—BCCTP	$0	-$2,179,000	$0	-$2,179,000	$0	$0
107	MH/UCD & BTR—DPH INTERIM RATE	$0	-$491,392,000	$0	-$392,395,000	$0	$98,997,000
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGR	$0	$0	$0	-$6,500,000	$0	-$6,500,000
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	$0	$0	-$8,959,000	$0	-$8,959,000
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVEF	$0	$0	-$13,000,000	$0	-$13,000,000	$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-$204,221,800	-$102,110,900	-$185,418,780	-$92,709,390	$18,803,020	$9,401,510
	WAIVER--MH/UCD & BTR SUBTOTAL	**$4,930,875,200**	**$1,116,585,100**	**$9,098,717,580**	**$2,931,803,290**	**$4,167,842,380**	**$1,815,218,190**
	MANAGED CARE						

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE						
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,252,660,000	$516,786,500	$1,481,657,000	$521,697,000	$228,997,000	$4,910,500
118	MANAGED CARE RATE RANGE IGTS	$820,130,000	$391,449,000	$860,767,000	$400,038,000	$40,637,000	$8,589,000
119	CCI-MANAGED CARE PAYMENTS	$5,706,904,000	$2,804,982,500	$6,901,009,000	$3,450,504,500	$1,194,105,000	$645,522,000
120	MANAGED CARE PUBLIC HOSPITAL IGTS	$399,710,000	$199,855,000	$431,688,000	$215,844,000	$31,978,000	$15,989,000
123	CCI-TRANSFER OF IHSS COSTS TO CDSS	$1,615,660,000	$1,615,660,000	$2,496,678,000	$2,496,678,000	$881,018,000	$881,018,000
124	RETRO MC RATE ADJUSTMENTS	$0	$0	$337,849,000	$168,924,500	$337,849,000	$168,924,500
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	-$16,426,000	-$8,213,000	-$26,934,000	-$13,467,000	-$10,508,000	-$5,254,000
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	$465,411,000	$231,818,200	$0	$0	-$465,411,000	-$231,818,200
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
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	$0	$0	-$1,071,000	-$535,500	-$1,071,000	-$535,500
143	CCI-SAVINGS AND DEFERRAL	-$3,788,843,000	-$1,894,421,500	-$4,502,299,000	-$2,251,149,500	-$713,456,000	-$356,728,000
	MANAGED CARE SUBTOTAL	**$6,457,206,000**	**$3,859,916,700**	**$7,981,344,000**	**$4,990,534,000**	**$1,524,138,000**	**$1,130,617,300**
	PROVIDER RATES						
24	AB 1629 ADD-ONS	$17,026,790	$8,513,400	$38,764,880	$19,382,440	$21,738,090	$10,869,050
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	$205,639,750	$102,819,870	$194,678,560	$97,339,280	-$10,961,190	-$5,480,590
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$187,060,400	$93,530,200	$125,322,250	$62,661,130	-$61,738,150	-$30,869,070
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYM	$42,657,000	$21,328,500	$90,068,000	$45,034,000	$47,411,000	$23,705,500
147	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$14,611,970	$7,306,880	$30,000,000	$15,000,000	$15,388,030	$7,693,120
148	LTC RATE ADJUSTMENT	$98,236,580	$49,118,290	$23,234,380	$11,617,190	-$75,002,200	-$37,501,100

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PROVIDER RATES						
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$14,425,830	$7,212,910	$18,905,100	$9,452,550	$4,479,270	$2,239,640
150	HOSPICE RATE INCREASES	$11,180,100	$5,590,050	$11,136,200	$5,568,100	-$43,910	-$21,950
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	$0	$0	$0	$0	$0	$0
152	NON-AB 1629 LTC RATE FREEZE	-$35,022,000	-$17,511,000	-$26,302,000	-$13,151,000	$8,720,000	$4,360,000
153	DENTAL RETROACTIVE RATE CHANGES	$0	$0	-$4,485,000	-$2,242,500	-$4,485,000	-$2,242,500
154	LABORATORY RATE METHODOLOGY CHANGE	-$14,715,900	-$7,357,950	-$10,900,700	-$5,450,350	$3,815,200	$1,907,600
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$34,256,000	-$17,128,000	-$29,896,510	-$14,948,260	$4,359,490	$2,179,740
156	REDUCTION TO RADIOLOGY RATES	-$60,399,470	-$30,199,740	-$32,891,820	-$16,445,910	$27,507,650	$13,753,820
157	10% PROVIDER PAYMENT REDUCTION	-$531,384,000	-$265,692,000	-$513,029,890	-$256,514,940	$18,354,110	$9,177,060
214	GENETIC DISEASE SCREENING PROGRAM FEE INCRE/	$0	$0	$7,619,000	$3,809,500	$7,619,000	$3,809,500
	PROVIDER RATES SUBTOTAL	**-$84,938,940**	**-$42,468,580**	**-$77,777,540**	**-$38,888,770**	**$7,161,400**	**$3,579,810**
	SUPPLEMENTAL PMNTS.						
158	HOSPITAL QAF - HOSPITAL PAYMENTS	$0	$0	$740,311,000	$416,522,000	$740,311,000	$416,522,000
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$7,024,244,000	$3,539,684,000	$6,945,877,000	$3,125,877,000	-$78,367,000	-$413,807,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$66,000,000	$0	$183,000,000	$0	$117,000,000	$0
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$50,000,000	$0	$20,000,000	$0	-$30,000,000	$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$186,774,000	$0	$197,287,000	$0	$10,513,000	$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	$70,000,000	$35,000,000	$70,000,000	$35,000,000	$0	$0
164	CERTIFICATION PAYMENTS FOR DP-NFS	$43,658,000	$0	$46,235,000	$0	$2,577,000	$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	$110,857,000	$45,211,000	$146,731,000	$63,461,500	$35,874,000	$18,250,500
166	FFP FOR LOCAL TRAUMA CENTERS	$70,000,000	$35,000,000	$70,000,000	$35,000,000	$0	$0
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:	$3,800,000	$0	$3,325,000	$0	-$475,000	$0

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	SUPPLEMENTAL PMNTS.						
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$7,658,333,000**	**$3,671,395,000**	**$8,455,766,000**	**$3,692,360,500**	**$797,433,000**	**$20,965,500**
	OTHER						
177	ARRA HITECH - PROVIDER PAYMENTS	$151,719,000	$0	$149,720,000	$0	-$1,999,000	$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDI	$88,060,000	$0	$107,104,000	$0	$19,044,000	$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	$8,501,000	$4,250,500	$61,544,000	$30,772,000	$53,043,000	$26,521,500
184	CDDS DENTAL SERVICES	$11,430,000	$11,430,000	$11,972,000	$11,972,000	$542,000	$542,000
185	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$16,415,000	$6,481,000	$16,415,000	$6,481,000	$0	$0
186	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$0	$0	$3,919,000	$1,176,000	$3,919,000	$1,176,000
187	AUDIT SETTLEMENTS	$627,000	$627,000	$9,910,000	$9,910,000	$9,283,000	$9,283,000
191	INDIAN HEALTH SERVICES	$2,180,000	-$9,435,500	$2,180,000	-$9,435,500	$0	$0
192	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0	$0	$0	$0
193	ANTI-FRAUD ACTIVITIES	-$15,000,000	-$7,500,000	$0	$0	$15,000,000	$7,500,000
194	CLPP FUND	$0	$0	$0	$0	$0	$0
196	AB 97 INJUNCTIONS	$0	$0	$0	$0	$0	$0
197	CCI-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	-$389,000	-$194,500	$0	$0	$389,000	$194,500
200	MEDICARE BUY-IN QUALITY REVIEW PROJECT	-$2,400,000	-$2,280,000	$0	$0	$2,400,000	$2,280,000
201	IHSS REDUCTION IN SERVICE HOURS	-$190,614,000	$0	-$212,833,000	$0	-$22,219,000	$0
216	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$0	$0	$209,000	$104,500	$209,000	$104,500
	OTHER SUBTOTAL	**$70,529,000**	**$3,378,500**	**$150,140,000**	**$50,980,000**	**$79,611,000**	**$47,601,500**
	GRAND TOTAL	**$29,662,329,040**	**$8,971,432,880**	**$43,631,189,840**	**$12,202,573,240**	**$13,968,860,800**	**$3,231,140,360**

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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	ELIGIBILITY						
2	FAMILY PACT PROGRAM	$576,793,000	$144,468,000	$587,160,000	$147,064,500	$10,367,000	$2,596,500
3	BREAST AND CERVICAL CANCER TREATMENT	$149,256,000	$65,896,100	$159,874,000	$69,940,000	$10,618,000	$4,043,900
4	AIM LINKED INFANTS 250-300% FPL	$31,629,000	$11,070,150	$33,232,000	$11,631,200	$1,603,000	$561,050
5	MEDI-CAL ADULT INMATE PROGRAMS	$14,092,000	$0	$27,477,000	$0	$13,385,000	$0
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	$4,518,000	$0	$5,469,000	$0	$951,000	$0
8	REFUGEES	$5,878,000	$5,878,000	$5,844,000	$5,844,000	-$34,000	-$34,000
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$0	$0	$1,726,000	$604,000	$1,726,000	$604,000
11	NEW QUALIFIED IMMIGRANTS	$0	$62,996,000	$0	$63,324,000	$0	$328,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	-$86,060,700	$0	-$86,018,250	$0	$42,450
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	-$8,927,700	$0	-$8,949,550	$0	-$21,850
14	INCARCERATION VERIFICATION PROGRAM	-$255,000	-$127,500	-$573,000	-$286,500	-$318,000	-$159,000
15	PARIS-FEDERAL	-$10,470,000	-$5,235,000	-$15,826,000	-$7,913,000	-$5,356,000	-$2,678,000
16	PARIS-VETERANS	-$2,541,570	-$1,270,780	-$4,041,760	-$2,020,880	-$1,500,200	-$750,100
17	PARIS-INTERSTATE	-$23,631,000	-$11,815,500	-$32,216,000	-$16,108,000	-$8,585,000	-$4,292,500
212	AIM LINKED MOTHERS 200-300% FPL	$0	$0	$126,172,000	$56,396,000	$126,172,000	$56,396,000
	ELIGIBILITY SUBTOTAL	**$745,268,430**	**$176,871,070**	**$894,297,240**	**$233,507,520**	**$149,028,800**	**$56,636,450**
	AFFORDABLE CARE ACT						
18	ACA OPTIONAL EXPANSION	$2,857,646,000	$1,768,000	$12,553,609,000	$6,283,000	$9,695,963,000	$4,515,000
19	PAYMENTS TO PRIMARY CARE PHYSICIANS	$1,629,619,590	$28,647,910	$745,128,630	$23,465,250	-$884,490,960	-$5,182,660
20	COMMUNITY FIRST CHOICE OPTION	$244,263,000	$0	$228,504,000	$0	-$15,759,000	$0
21	ACA MANDATORY EXPANSION	$419,928,000	$193,414,050	$1,993,963,000	$929,905,350	$1,574,035,000	$736,491,300
22	MENTAL HEALTH SERVICES EXPANSION	$86,512,000	$31,682,650	$391,459,000	$138,584,950	$304,947,000	$106,902,300
23	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	$33,935,000	$0	$67,870,000	$0	$33,935,000	$0
25	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$10,390,000	$2,202,400	$98,079,000	$18,945,250	$87,689,000	$16,742,850
26	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$14,493,000	$5,254,000	$56,924,000	$20,638,000	$42,431,000	$15,384,000

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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	AFFORDABLE CARE ACT						
27	USPSTF GRADE A AND B RECOMMENDATIONS	$11,693,440	$4,291,650	$90,749,790	$29,176,740	$79,056,350	$24,885,090
28	ACA DELAY OF REDETERMINATIONS	$150,904,000	$70,579,550	$53,303,000	$26,011,700	-$97,601,000	-$44,567,850
29	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	$115,000	$0	$115,000	$0	$0
30	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	-$45,932,000	$0	-$39,582,000	$0	$6,350,000
31	RECOVERY AUDIT CONTRACTOR SAVINGS	-$2,060	-$1,030	-$76,610	-$38,310	-$74,550	-$37,280
34	MANAGED CARE DRUG REBATES	-$379,500,000	-$189,750,000	-$330,400,000	-$165,200,000	$49,100,000	$24,550,000
205	HEALTH INSURER FEE	$0	$0	$121,306,000	$54,587,500	$121,306,000	$54,587,500
206	ACA EXPRESS LANE ENROLLMENT	$413,611,000	$5,975,800	$1,508,167,000	$59,423,050	$1,094,556,000	$53,447,250
210	ACA EXPANSION-PREGNANCY ONLY	$0	$0	-$33,145,000	-$16,572,500	-$33,145,000	-$16,572,500
217	ACA MAGI SAVINGS	$0	-$2,303,000	$0	-$17,742,000	$0	-$15,439,000
	AFFORDABLE CARE ACT SUBTOTAL	**$5,493,492,970**	**$105,944,980**	**$17,545,440,810**	**$1,068,000,980**	**$12,051,947,840**	**$962,056,000**
	BENEFITS						
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$182,932,000	$0	$312,967,000	$0	$130,035,000	$0
36	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$144,983,000	$0	$144,536,000	$0	-$447,000	$0
37	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$45,621,000	$1,478,000	$26,085,000	$2,819,000	-$19,536,000	$1,341,000
38	RESTORATION OF SELECT ADULT DENTAL BENEFITS	$9,121,000	$3,173,000	$311,879,000	$109,948,000	$302,758,000	$106,775,000
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	$34,320,000	$17,160,000	$34,170,000	$17,085,000	-$150,000	-$75,000
41	YOUTH REGIONAL TREATMENT CENTERS	$3,910,000	$776,000	$6,345,000	$34,000	$2,435,000	-$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	$2,477,000	$0	$3,912,000	$0	$1,435,000	$0
44	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$540,000	$270,000	$0	$0
45	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$226,000	$0	$516,000	$0	$290,000	$0
46	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$139,000	$0	$150,000	$0	$11,000	$0
49	SCHIP FUNDING FOR PRENATAL CARE	$0	-$89,107,200	$0	-$92,502,800	$0	-$3,395,600

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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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	BENEFITS						
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	-$2,237,990	-$2,086,550	-$20,645,660	-$4,388,190	-$18,407,670	-$2,301,640
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$14,073,000	-$7,036,500	-$20,218,000	-$10,109,000	-$6,145,000	-$3,072,500
66	VOLUNTARY INPATIENT DETOXIFICATION	$10,179,000	$4,092,500	$28,925,000	$10,622,500	$18,746,000	$6,530,000
208	DENTAL CHILDREN'S OUTREACH AGES 0-3	$0	$0	$17,636,000	$8,146,000	$17,636,000	$8,146,000
	BENEFITS SUBTOTAL	**$463,232,010**	**-$48,733,250**	**$858,395,340**	**$47,723,510**	**$395,163,330**	**$96,456,760**
	PHARMACY						
53	RESTORATION OF ENTERAL NUTRITION BENEFIT	$3,383,020	$1,691,510	$28,646,420	$14,323,210	$25,263,400	$12,631,700
54	NON FFP DRUGS	$0	$2,044,500	$0	$2,106,000	$0	$61,500
55	BCCTP DRUG REBATES	-$15,389,000	-$5,386,150	-$15,764,000	-$5,517,400	-$375,000	-$131,250
56	MEDICAL SUPPLY REBATES	-$24,428,000	-$12,214,000	-$24,428,000	-$12,214,000	$0	$0
57	FAMILY PACT DRUG REBATES	-$78,108,000	-$10,000,800	-$73,085,000	-$9,357,700	$5,023,000	$643,100
58	LITIGATION SETTLEMENTS	-$88,253,000	-$88,253,000	$0	$0	$88,253,000	$88,253,000
59	AGED AND DISPUTED DRUG REBATES	-$286,000,000	-$142,973,600	-$196,000,000	-$97,982,000	$90,000,000	$44,991,600
60	STATE SUPPLEMENTAL DRUG REBATES	-$209,567,000	-$102,848,700	-$161,296,000	-$79,158,800	$48,271,000	$23,689,900
61	FEDERAL DRUG REBATE PROGRAM	-$1,378,767,000	-$599,064,200	-$1,299,000,000	-$559,917,100	$79,767,000	$39,147,100
211	MCO SUPPLEMENTAL DRUG REBATE	$0	$0	-$65,000,000	-$32,500,000	-$65,000,000	-$32,500,000
219	VISION OUTREACH	$0	$0	$2,036,000	$1,018,000	$2,036,000	$1,018,000
	PHARMACY SUBTOTAL	**-$2,077,128,980**	**-$957,004,440**	**-$1,803,890,580**	**-$779,199,790**	**$273,238,400**	**$177,804,650**
	DRUG MEDI-CAL						
67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$0	$3,036,000	$0	$0	$0
68	ANNUAL RATE ADJUSTMENT	$0	$0	-$2,607,000	-$248,000	-$2,607,000	-$248,000
	DRUG MEDI-CAL SUBTOTAL	**$3,036,000**	**$0**	**$429,000**	**-$248,000**	**-$2,607,000**	**-$248,000**
	MENTAL HEALTH						
71	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	$64,187,000	$0	$353,018,000	$0	$288,831,000	$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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MENTAL HEALTH						
72	ELIMINATION OF STATE MAXIMUM RATES	$67,962,000	$0	$72,161,000	$0	$4,199,000	$0
73	TRANSITION OF HFP - SMH SERVICES	$29,886,000	$0	$41,848,000	$0	$11,962,000	$0
74	KATIE A. V. DIANA BONTA	$29,293,000	$0	$26,751,000	$0	-$2,542,000	$0
75	HEALTHY FAMILIES - SED	$18,769,000	$0	$7,070,000	$0	-$11,699,000	$0
76	INVESTMENT IN MENTAL HEALTH WELLNESS	$12,400,000	$0	$24,800,000	$0	$12,400,000	$0
77	OVER ONE-YEAR CLAIMS	$3,353,000	$0	$3,000,000	$0	-$353,000	$0
78	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	$2,270,000	$0	$0	$0	-$2,270,000	$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	-$1,271,000	$0	-$320,000	$0	$951,000	$0
83	INTERIM AND FINAL COST SETTLEMENTS - SMHS	-$41,760,000	$27,777,000	$0	$0	$41,760,000	-$27,777,000
	MENTAL HEALTH SUBTOTAL	**$185,089,000**	**$40,981,000**	**$528,328,000**	**$6,000,000**	**$343,239,000**	**-$34,981,000**
	WAIVER--MH/UCD & BTR						
84	BTR - LIHP - MCE	$1,039,826,000	$127,029,500	$4,210,969,000	$1,985,006,000	$3,171,143,000	$1,857,976,500
85	MH/UCD & BTR—DSH PAYMENT	$1,655,852,000	$396,202,000	$1,762,250,000	$592,433,000	$106,398,000	$196,231,000
86	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE PC	$1,474,435,000	$737,217,500	$1,152,624,000	$576,312,000	-$321,811,000	-$160,905,500
87	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEME	$608,376,000	$304,188,000	$551,013,000	$275,506,500	-$57,363,000	-$28,681,500
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	$250,602,000	$125,301,000	$268,001,000	$134,000,500	$17,399,000	$8,699,500
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$134,376,000	$23,076,000	$21,373,000	$0	-$113,003,000	-$23,076,000
91	MH/UCD & BTR—CCS AND GHPP	$134,565,000	$0	$117,158,000	$0	-$17,407,000	$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	$19,933,000	$12,095,000	$275,629,000	$135,686,000	$255,696,000	$123,591,000
94	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$84,400,000	$0	$85,000,000	$0	$600,000	$0
95	BTR—DESIGNATED STATE HEALTH PROGRAMS	$8,315,000	-$246,770,000	$53,645,000	-$286,449,000	$45,330,000	-$39,679,000

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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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR						
96	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMA	$53,642,000	$0	$0	$0	-$53,642,000	$0
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$0	$0	$20,369,360	$10,184,680	$20,369,360	$10,184,680
98	BTR—INCREASE SAFETY NET CARE POOL	$24,250,000	$0	$6,500,000	$0	-$17,750,000	$0
99	MH/UCD—STABILIZATION FUNDING	$13,988,000	$13,988,000	$41,378,000	$29,628,000	$27,390,000	$15,640,000
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$11,877,000	$0	$435,143,000	$0	$423,266,000	$0
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	$3,786,000	$0	$2,370,000	$0	-$1,416,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$9,500,000	$0	$0	$0	-$9,500,000	$0
103	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$7,600,000	$3,800,000	$4,712,000	$2,356,000	-$2,888,000	-$1,444,000
104	MH/UCD—SAFETY NET CARE POOL	$1,949,000	$0	$46,752,000	$0	$44,803,000	$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	-$365,021,500	$0	-$392,395,000	$0	-$27,373,500
108	BTR—INCREASE DESIGNATED STATE HEALTH PROGR	$0	-$24,250,000	$0	-$6,500,000	$0	$17,750,000
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	$24,503,000	$0	-$8,959,000	$0	-$33,462,000
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVEI	-$48,500,000	$0	-$13,000,000	$0	$35,500,000	$0
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-$80,809,280	-$40,404,640	-$185,418,780	-$92,709,390	-$104,609,500	-$52,304,750
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,835,212,720**	**$1,124,840,860**	**$9,098,717,580**	**$2,931,803,290**	**$3,263,504,860**	**$1,806,962,430**
	MANAGED CARE						
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$798,599,000	$331,195,000	$1,481,657,000	$521,697,000	$683,058,000	$190,502,000
118	MANAGED CARE RATE RANGE IGTS	$739,514,000	$343,686,000	$860,767,000	$400,038,000	$121,253,000	$56,352,000
119	CCI-MANAGED CARE PAYMENTS	$98,877,000	$49,438,500	$6,901,009,000	$3,450,504,500	$6,802,132,000	$3,401,066,000
120	MANAGED CARE PUBLIC HOSPITAL IGTS	$783,992,000	$391,996,000	$431,688,000	$215,844,000	-$352,304,000	-$176,152,000
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	$371,327,000	$185,663,500	$0	$0	-$371,327,000	-$185,663,500
123	CCI-TRANSFER OF IHSS COSTS TO CDSS	$39,821,000	$39,821,000	$2,496,678,000	$2,496,678,000	$2,456,857,000	$2,456,857,000
124	RETRO MC RATE ADJUSTMENTS	$0	$0	$337,849,000	$168,924,500	$337,849,000	$168,924,500

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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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE						
127	MANAGED CARE EXPANSION TO RURAL COUNTIES	$1,079,000	$539,500	-$26,934,000	-$13,467,000	-$28,013,000	-$14,006,500
128	INCREASE IN CAPITATION RATES FOR GROSS PREMIU	$8,236,000	$4,050,050	$0	$0	-$8,236,000	-$4,050,050
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	$0	$0	$0	$0
133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO (	$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	$0	$0	-$1,071,000	-$535,500	-$1,071,000	-$535,500
143	CCI-SAVINGS AND DEFERRAL	-$76,030,000	-$38,015,000	-$4,502,299,000	-$2,251,149,500	-$4,426,269,000	-$2,213,134,500
	MANAGED CARE SUBTOTAL	**$2,767,415,000**	**$1,310,374,550**	**$7,981,344,000**	**$4,990,534,000**	**$5,213,929,000**	**$3,680,159,450**
	PROVIDER RATES						
24	AB 1629 ADD-ONS	$3,138,740	$1,569,370	$38,764,880	$19,382,440	$35,626,140	$17,813,070
144	FQHC/RHC/CBRC RECONCILIATION PROCESS	$256,869,140	$128,434,570	$194,678,560	$97,339,280	-$62,190,580	-$31,095,290
145	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$5,078,260	$2,539,130	$125,322,250	$62,661,130	$120,243,990	$60,122,000
146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYM	$45,489,000	$22,744,500	$90,068,000	$45,034,000	$44,579,000	$22,289,500
147	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$22,000,000	$11,000,000	$30,000,000	$15,000,000	$8,000,000	$4,000,000
148	LTC RATE ADJUSTMENT	$13,411,550	$6,705,770	$23,234,380	$11,617,190	$9,822,830	$4,911,420
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$15,551,300	$7,775,650	$18,905,100	$9,452,550	$3,353,800	$1,676,900
150	HOSPICE RATE INCREASES	$4,461,220	$2,230,610	$11,136,200	$5,568,100	$6,674,980	$3,337,490

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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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PROVIDER RATES						
151	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	$0	$0	$0	$0	$0	$0
152	NON-AB 1629 LTC RATE FREEZE	-$30,000	-$15,000	-$26,302,000	-$13,151,000	-$26,272,000	-$13,136,000
153	DENTAL RETROACTIVE RATE CHANGES	$0	$0	-$4,485,000	-$2,242,500	-$4,485,000	-$2,242,500
154	LABORATORY RATE METHODOLOGY CHANGE	$0	$0	-$10,900,700	-$5,450,350	-$10,900,700	-$5,450,350
155	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$1,773,850	-$886,920	-$29,896,510	-$14,948,260	-$28,122,670	-$14,061,330
156	REDUCTION TO RADIOLOGY RATES	$0	$0	-$32,891,820	-$16,445,910	-$32,891,820	-$16,445,910
157	10% PROVIDER PAYMENT REDUCTION	-$278,751,530	-$139,375,770	-$513,029,890	-$256,514,940	-$234,278,350	-$117,139,180
214	GENETIC DISEASE SCREENING PROGRAM FEE INCREA	$0	$0	$7,619,000	$3,809,500	$7,619,000	$3,809,500
	PROVIDER RATES SUBTOTAL	**$85,443,840**	**$42,721,920**	**-$77,777,540**	**-$38,888,770**	**-$163,221,370**	**-$81,610,690**
	SUPPLEMENTAL PMNTS.						
158	HOSPITAL QAF - HOSPITAL PAYMENTS	$3,767,106,000	$1,894,165,000	$740,311,000	$416,522,000	-$3,026,795,000	-$1,477,643,000
159	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$0	$0	$6,945,877,000	$3,125,877,000	$6,945,877,000	$3,125,877,000
160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$0	$0	$183,000,000	$0	$183,000,000	$0
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$100,000,000	$0	$20,000,000	$0	-$80,000,000	$0
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$172,138,000	$0	$197,287,000	$0	$25,149,000	$0
163	NDPH IGT SUPPLEMENTAL PAYMENTS	$135,742,000	$67,871,000	$70,000,000	$35,000,000	-$65,742,000	-$32,871,000
164	CERTIFICATION PAYMENTS FOR DP-NFS	$89,899,000	$0	$46,235,000	$0	-$43,664,000	$0
165	CAPITAL PROJECT DEBT REIMBURSEMENT	$120,632,000	$50,412,000	$146,731,000	$63,461,500	$26,099,000	$13,049,500
166	FFP FOR LOCAL TRAUMA CENTERS	$100,000,000	$50,000,000	$70,000,000	$35,000,000	-$30,000,000	-$15,000,000
167	IGT PAYMENTS FOR HOSPITAL SERVICES	$11,000,000	$5,500,000	$15,000,000	$7,500,000	$4,000,000	$2,000,000
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:	$4,725,000	$0	$3,325,000	$0	-$1,400,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$4,519,242,000**	**$2,076,948,000**	**$8,455,766,000**	**$3,692,360,500**	**$3,936,524,000**	**$1,615,412,500**
	OTHER						

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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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
177	ARRA HITECH - PROVIDER PAYMENTS	$315,564,000	$0	$149,720,000	$0	-$165,844,000	$0
178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDI	$120,670,000	$0	$107,104,000	$0	-$13,566,000	$0
183	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	$72,905,000	$36,452,500	$61,544,000	$30,772,000	-$11,361,000	-$5,680,500
184	CDDS DENTAL SERVICES	$11,972,000	$11,972,000	$11,972,000	$11,972,000	$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	$3,918,000	$1,175,000	$3,919,000	$1,176,000	$1,000	$1,000
187	AUDIT SETTLEMENTS	$8,247,000	$8,247,000	$9,910,000	$9,910,000	$1,663,000	$1,663,000
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
194	CLPP FUND	$0	$0	$0	$0	$0	$0
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0	$0	$0	$0
197	CCI-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
201	IHSS REDUCTION IN SERVICE HOURS	-$218,342,000	$0	-$212,833,000	$0	$5,509,000	$0
216	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$0	$0	$209,000	$104,500	$209,000	$104,500
	OTHER SUBTOTAL	**$336,753,000**	**$57,151,000**	**$150,140,000**	**$50,980,000**	**-$186,613,000**	**-$6,171,000**
	GRAND TOTAL	**$18,357,055,990**	**$3,930,095,680**	**$43,631,189,840**	**$12,202,573,240**	**$25,274,133,850**	**$8,272,477,560**

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

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	PA-OAS	PA-AB	PA-ATD	PA-AFDC	LT-OAS	LT-AB
PHYSICIANS	$25,816,510	$2,832,920	$125,362,390	$55,073,590	$3,895,540	$66,270
OTHER MEDICAL	$46,615,640	$7,573,300	$306,912,690	$320,413,410	$6,927,670	$223,440
COUNTY OUTPATIENT	$350,140	$54,000	$4,197,870	$1,338,420	$126,650	$150
COMMUNITY OUTPATIENT	$6,923,660	$1,290,830	$102,099,940	$25,446,990	$498,170	$8,830
PHARMACY	-$1,744,150	$694,260	$46,780,120	$64,904,880	-$644,830	-$10,310
COUNTY INPATIENT	$8,713,250	$935,300	$70,429,570	$34,461,420	$2,363,750	$520
COMMUNITY INPATIENT	$81,444,700	$10,780,620	$592,999,350	$279,306,730	$21,664,570	$298,100
NURSING FACILITIES	$340,083,490	$14,390,340	$513,709,850	$2,975,290	$1,306,766,910	$5,249,300
ICF-DD	$248,880	$5,291,530	$109,305,900	$365,880	$17,338,850	$1,782,210
MEDICAL TRANSPORTATION	$12,845,620	$2,781,530	$35,490,660	$3,667,050	$3,711,790	$73,650
OTHER SERVICES	$41,203,670	$4,362,990	$106,366,620	$39,480,050	$57,922,970	$154,190
HOME HEALTH	$285,120	$8,428,100	$108,140,910	$4,294,630	$14,910	$0
FFS SUBTOTAL	**$562,786,540**	**$59,415,710**	**$2,121,795,860**	**$831,728,350**	**$1,420,586,940**	**$7,846,350**
DENTAL	$43,693,450	$2,233,560	$102,679,250	$151,098,570	$4,748,990	$23,320
TWO PLAN MODEL	$765,683,330	$122,814,070	$7,607,895,400	$1,773,966,690	-$280,230	-$280,230
COUNTY ORGANIZED HEALTH SYSTEMS	$324,924,290	$29,165,780	$1,498,877,950	$411,440,850	$817,337,810	$10,074,850
GEOGRAPHIC MANAGED CARE	$133,077,310	$22,484,520	$1,373,621,130	$304,697,440	-$48,320	-$48,320
PHP & OTHER MANAG. CARE	$168,598,640	$3,886,430	$106,335,030	$110,840,680	$8,020,500	$6,020
EPSDT SCREENS	$0	$0	$0	$8,392,970	$0	$0
MEDICARE PAYMENTS	$1,375,186,670	$40,755,230	$1,287,158,320	$0	$146,645,720	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$106,010	$1,537,150	$58,994,900	$583,060	$14,019,900	$1,060,110
MISC. SERVICES	$825,353,360	$44,687,210	$3,864,027,610	$793,330	$8,290	$0
NON-FFS SUBTOTAL	**$3,636,623,080**	**$267,563,960**	**$15,899,589,590**	**$2,761,813,590**	**$990,452,660**	**$10,835,750**
TOTAL DOLLARS (1)	**$4,199,409,610**	**$326,979,670**	**$18,021,385,460**	**$3,593,541,940**	**$2,411,039,600**	**$18,682,100**
ELIGIBLES ***	**426,500**	**21,700**	**1,030,500**	**1,455,000**	**46,000**	**200**
ANNUAL $/ELIGIBLE	**$9,846**	**$15,068**	**$17,488**	**$2,470**	**$52,414**	**$93,410**
AVG. MO. $/ELIGIBLE	**$821**	**$1,256**	**$1,457**	**$206**	**$4,368**	**$7,784**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-AB	MN-ATD	MN-AFDC
PHYSICIANS	$6,082,950	$20,985,090	$21,462,580	$427,050	$60,547,710	$310,393,610
OTHER MEDICAL	$5,649,910	$111,808,610	$53,523,040	$1,079,750	$113,662,570	$1,035,378,320
COUNTY OUTPATIENT	$276,550	$759,360	$646,030	$28,140	$6,335,600	$20,730,740
COMMUNITY OUTPATIENT	$719,860	$17,039,550	$6,175,780	$79,710	$31,464,770	$135,056,690
PHARMACY	-$1,065,880	$67,309,920	-$1,285,710	$124,900	$47,825,980	$230,906,240
COUNTY INPATIENT	$20,419,470	$6,334,230	$21,895,310	$778,480	$184,322,450	$339,760,430
COMMUNITY INPATIENT	$32,892,330	$90,724,790	$62,617,760	$1,690,280	$418,872,220	$1,675,455,240
NURSING FACILITIES	$389,876,090	$509,200	$164,361,470	$475,660	$57,315,270	$18,164,000
ICF-DD	$91,640,920	$119,700	$451,550	$0	$5,910,270	$299,370
MEDICAL TRANSPORTATION	$2,063,270	$712,960	$10,353,110	$240,810	$21,028,730	$14,885,190
OTHER SERVICES	$11,769,050	$29,094,560	$19,397,110	$133,600	$42,740,540	$107,588,570
HOME HEALTH	$29,290	$4,407,050	$326,330	$2,050	$44,308,690	$10,989,660
FFS SUBTOTAL	**$560,353,810**	**$349,805,030**	**$359,924,370**	**$5,060,430**	**$1,034,334,800**	**$3,899,608,050**
DENTAL	$1,526,790	$69,677,290	$31,478,600	$64,790	$19,847,090	$418,809,320
TWO PLAN MODEL	-$280,230	$565,838,570	$1,198,145,410	$3,978,770	$776,697,670	$3,651,157,750
COUNTY ORGANIZED HEALTH SYSTEMS	$292,187,920	$257,875,200	$298,383,040	$666,360	$370,842,260	$1,235,196,650
GEOGRAPHIC MANAGED CARE	-$48,320	$110,872,790	$130,314,940	$167,890	$122,644,200	$537,966,990
PHP & OTHER MANAG. CARE	$297,330	$48,664,180	$137,565,960	$195,240	$16,693,980	$251,300,110
EPSDT SCREENS	$0	$5,376,380	$0	$0	$0	$20,052,440
MEDICARE PAYMENTS	$37,259,840	$0	$717,813,490	$0	$361,926,860	$70,999,880
STATE HOSP./DEVELOPMENTAL CNTRS.	$187,241,220	$0	$26,500	$26,500	$238,520	$132,510
MISC. SERVICES	$2,650	$0	$69,226,020	$1,165,750	$728,576,350	$2,017,280
NON-FFS SUBTOTAL	**$518,187,200**	**$1,058,304,400**	**$2,582,953,960**	**$6,265,310**	**$2,397,466,920**	**$6,187,632,930**
TOTAL DOLLARS (1)	**$1,078,541,010**	**$1,408,109,430**	**$2,942,878,330**	**$11,325,740**	**$3,431,801,720**	**$10,087,240,980**
ELIGIBLES ***	**14,800**	**919,500**	**328,600**	**600**	**191,600**	**4,155,500**
ANNUAL $/ELIGIBLE	**$72,874**	**$1,531**	**$8,956**	**$18,876**	**$17,911**	**$2,427**
AVG. MO. $/ELIGIBLE	**$6,073**	**$128**	**$746**	**$1,573**	**$1,493**	**$202**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	MI-C	MI-A	REFUGEE	OBRA	POV 185	POV 133
PHYSICIANS	$43,014,900	$118,934,170	$324,610	$41,262,130	$263,392,220	$4,185,020
OTHER MEDICAL	$158,658,870	$1,201,495,070	$1,744,910	$74,601,750	$288,393,080	$59,911,660
COUNTY OUTPATIENT	$2,074,250	$9,238,940	$115,650	$9,123,440	$4,224,930	$132,440
COMMUNITY OUTPATIENT	$18,727,350	$35,617,800	$150,740	$11,496,380	$37,683,770	$2,939,510
PHARMACY	$59,109,530	$369,931,320	$747,680	$21,699,600	$19,186,920	$3,574,590
COUNTY INPATIENT	$24,554,890	$51,419,820	$34,020	$71,868,780	$99,454,880	$990,040
COMMUNITY INPATIENT	$139,300,940	$401,549,130	$537,950	$115,778,800	$625,033,140	$17,520,010
NURSING FACILITIES	$7,070,450	$38,526,580	$48,030	$21,906,390	$112,180	$462,270
ICF-DD	$1,784,090	$720,500	$0	$313,530	$0	$0
MEDICAL TRANSPORTATION	$2,555,200	$19,178,220	$14,340	$7,874,920	$2,444,710	$171,060
OTHER SERVICES	$26,873,730	$35,773,150	$17,030	$4,557,770	$19,468,980	$12,102,900
HOME HEALTH	$13,447,910	$159,780	$250	$15,130	$1,646,570	$1,383,160
FFS SUBTOTAL	**$497,172,100**	**$2,282,544,480**	**$3,735,200**	**$380,498,610**	**$1,361,041,370**	**$103,372,660**
DENTAL	$19,909,320	$38,429,610	$159,180	$283,060	$2,043,330	$12,884,880
TWO PLAN MODEL	$71,464,460	$6,278,094,510	$1,363,160	$0	$68,234,430	$191,392,380
COUNTY ORGANIZED HEALTH SYSTEMS	$52,570,540	$2,691,856,500	$319,550	$714,930	$34,594,820	$87,580,570
GEOGRAPHIC MANAGED CARE	$13,531,100	$996,186,550	$572,890	$0	$15,485,760	$48,388,120
PHP & OTHER MANAG. CARE	$4,303,340	$0	$0	$0	$5,078,690	$11,106,930
EPSDT SCREENS	$1,359,240	$0	$0	$0	$0	$1,012,230
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$453,710	$26,500	$0	$238,520	$79,510	$0
MISC. SERVICES	$6,337,050	$68,134,220	$0	$0	$110,300	$152,960
NON-FFS SUBTOTAL	**$169,928,760**	**$10,072,727,890**	**$2,414,780**	**$1,236,520**	**$125,626,820**	**$352,518,080**
TOTAL DOLLARS (1)	**$667,100,860**	**$12,355,272,380**	**$6,149,970**	**$381,735,120**	**$1,486,668,190**	**$455,890,740**
ELIGIBLES ***	**266,400**	**1,824,700**	**2,600**	**120,500**	**229,200**	**206,000**
ANNUAL $/ELIGIBLE	**$2,504**	**$6,771**	**$2,365**	**$3,168**	**$6,486**	**$2,213**
AVG. MO. $/ELIGIBLE	**$209**	**$564**	**$197**	**$264**	**$541**	**$184**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

SERVICE CATEGORY	POV 100	TOTAL
PHYSICIANS	$6,767,040	**$1,110,826,310**
OTHER MEDICAL	$45,741,980	**$3,840,315,640**
COUNTY OUTPATIENT	$382,510	**$60,135,790**
COMMUNITY OUTPATIENT	$5,103,700	**$438,524,030**
PHARMACY	$13,419,210	**$941,464,260**
COUNTY INPATIENT	$3,643,090	**$942,379,690**
COMMUNITY INPATIENT	$28,306,730	**$4,596,773,380**
NURSING FACILITIES	$618,830	**$2,882,621,610**
ICF-DD	$4,890	**$235,578,070**
MEDICAL TRANSPORTATION	$285,270	**$140,378,080**
OTHER SERVICES	$8,015,250	**$567,022,730**
HOME HEALTH	$1,669,140	**$199,548,690**
FFS SUBTOTAL	**$113,957,630**	**$15,955,568,290**
DENTAL	$15,728,510	**$935,318,910**
TWO PLAN MODEL	$240,721,450	**$23,316,607,370**
COUNTY ORGANIZED HEALTH SYSTEMS	$92,397,540	**$8,507,007,420**
GEOGRAPHIC MANAGED CARE	$62,130,470	**$3,871,997,150**
PHP & OTHER MANAG. CARE	$12,690,830	**$885,583,880**
EPSDT SCREENS	$1,310,820	**$37,504,080**
MEDICARE PAYMENTS	$0	**$4,037,746,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	$265,030	**$265,029,670**
MISC. SERVICES	$54,070	**$5,610,646,450**
NON-FFS SUBTOTAL	**$425,298,720**	**$47,467,440,920**
TOTAL DOLLARS (1)	**$539,256,350**	**$63,423,009,210**
ELIGIBLES ***	**260,600**	**11,500,500**
ANNUAL $/ELIGIBLE	**$2,069**	**$5,515**
AVG. MO. $/ELIGIBLE	**$172**	**$460**

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

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

Excluded policy changes: 71. Refer to page following report for listing.

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 71

2	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
10	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
49	SCHIP FUNDING FOR PRENATAL CARE
51	WOMEN'S HEALTH SERVICES
54	NON FFP DRUGS
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
104	MH/UCD—SAFETY NET CARE POOL

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 71

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
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS
123	CCI-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 PAYMENTS
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
180	MEDI-CAL TCM PROGRAM

FISCAL YEAR 2014-15 COST PER ELIGIBLE BASED ON MAY 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 71

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

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

TOTAL FOR ALL SERVICES ACROSS ALL BASE AID CATEGORIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	1,656,950	4.49	$175.10	$785.86	$3,906,398,000
2012-13 *	4	1,521,830	4.24	$171.26	$726.43	$3,316,496,900
2012-13 *	TOTAL	1,616,010	4.52	$175.48	$793.32	$15,384,167,000
2013-14 *	1	1,740,310	4.91	$179.67	$882.12	$4,605,491,000
2013-14 *	2	1,636,680	4.45	$174.36	$775.45	$3,807,509,300
2013-14 **	3	1,649,600	4.40	$180.65	$794.08	$3,929,727,200
2013-14 **	4	1,478,180	4.39	$178.71	$783.98	$3,476,601,700
2013-14 **	TOTAL	1,626,190	4.54	$178.39	$810.65	$15,819,329,300
2014-15 **	1	1,686,950	4.97	$183.46	$911.03	$4,610,587,200
2014-15 **	2	1,574,400	4.59	$183.68	$842.61	$3,979,818,600
2014-15 **	3	1,587,350	4.58	$183.58	$841.54	$4,007,448,900
2014-15 **	4	1,466,850	4.45	$180.55	$802.96	$3,533,448,600
2014-15 **	TOTAL	1,578,880	4.66	$182.90	$851.41	$16,131,303,300

* 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 SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	491,900	2.09	$74.59	$155.82	$229,941,200
2012-13 *	4	423,980	2.07	$72.41	$149.76	$190,490,400
2012-13 *	TOTAL	450,130	2.13	$75.62	$161.00	$869,646,300
2013-14 *	1	481,170	2.25	$75.84	$170.32	$245,851,800
2013-14 *	2	421,280	2.16	$75.45	$162.69	$205,616,100
2013-14 **	3	468,470	2.06	$69.47	$143.30	$201,399,600
2013-14 **	4	395,800	2.07	$69.05	$143.09	$169,904,700
2013-14 **	TOTAL	441,680	2.14	$72.64	$155.24	$822,772,100
2014-15 **	1	446,910	2.30	$71.83	$165.40	$221,764,600
2014-15 **	2	392,710	2.18	$71.69	$155.97	$183,749,200
2014-15 **	3	459,130	2.09	$69.76	$145.47	$200,376,200
2014-15 **	4	394,400	2.08	$69.28	$144.35	$170,791,000
2014-15 **	TOTAL	423,290	2.16	$70.68	$152.91	$776,681,000

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	727,760	1.63	$132.48	$215.85	$471,257,200
2012-13 *	4	650,080	1.59	$141.50	$225.55	$439,887,800
2012-13 *	TOTAL	698,010	1.64	$133.54	$218.37	$1,829,060,700
2013-14 *	1	803,930	1.68	$156.64	$263.09	$634,517,000
2013-14 *	2	741,000	1.62	$136.83	$222.04	$493,594,800
2013-14 **	3	754,460	1.60	$138.17	$221.29	$500,866,000
2013-14 **	4	682,340	1.58	$140.10	$221.76	$453,949,300
2013-14 **	TOTAL	745,430	1.62	$143.42	$232.85	$2,082,927,100
2014-15 **	1	805,920	1.71	$138.98	$237.32	$573,788,900
2014-15 **	2	746,770	1.62	$139.57	$226.64	$507,739,100
2014-15 **	3	746,400	1.62	$138.20	$223.31	$500,043,100
2014-15 **	4	680,160	1.59	$140.13	$222.57	$454,152,400
2014-15 **	TOTAL	744,810	1.64	$139.19	$227.77	$2,035,723,500

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

COUNTY OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	20,560	1.63	$123.12	$200.90	$12,392,300
2012-13 *	4	21,130	1.70	$110.05	$186.99	$11,852,200
2012-13 *	TOTAL	22,660	1.73	$110.00	$189.90	$51,633,400
2013-14 *	1	24,640	1.71	$113.68	$194.55	$14,382,400
2013-14 *	2	23,710	1.65	$95.38	$157.83	$11,223,700
2013-14 **	3	22,580	1.59	$115.61	$183.49	$12,427,800
2013-14 **	4	19,390	1.65	$102.52	$168.71	$9,814,300
2013-14 **	TOTAL	22,580	1.65	$106.94	$176.60	$47,848,200
2014-15 **	1	23,430	1.74	$108.58	$188.81	$13,272,800
2014-15 **	2	21,880	1.66	$106.77	$176.78	$11,604,300
2014-15 **	3	20,960	1.61	$115.49	$185.38	$11,654,100
2014-15 **	4	19,300	1.65	$104.14	$171.92	$9,956,000
2014-15 **	TOTAL	21,390	1.67	$108.76	$181.08	$46,487,100

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

COMMUNITY OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	191,400	1.63	$105.77	$172.76	$99,196,400
2012-13 *	4	184,510	1.66	$95.05	$157.97	$87,441,900
2012-13 *	TOTAL	203,520	1.65	$102.09	$168.50	$411,514,900
2013-14 *	1	240,000	1.60	$116.64	$187.01	$134,644,700
2013-14 *	2	228,030	1.58	$95.86	$151.13	$103,389,700
2013-14 **	3	207,850	1.54	$103.36	$159.26	$99,304,900
2013-14 **	4	199,880	1.57	$95.75	$150.72	$90,374,900
2013-14 **	TOTAL	218,940	1.57	$103.37	$162.80	$427,714,100
2014-15 **	1	244,270	1.68	$96.79	$162.38	$118,989,400
2014-15 **	2	214,030	1.59	$95.85	$152.78	$98,097,100
2014-15 **	3	206,580	1.56	$101.41	$158.38	$98,152,400
2014-15 **	4	198,900	1.59	$95.02	$150.84	$90,007,000
2014-15 **	TOTAL	215,940	1.61	$97.23	$156.39	$405,245,900

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	628,030	2.97	$106.82	$317.53	$598,243,400
2012-13 *	4	529,370	2.88	$111.46	$321.19	$510,076,300
2012-13 *	TOTAL	615,860	2.98	$105.34	$314.39	$2,323,405,000
2013-14 *	1	621,950	3.22	$117.10	$377.62	$704,586,200
2013-14 *	2	543,530	2.99	$121.62	$363.56	$592,812,000
2013-14 **	3	545,550	2.93	$130.43	$382.53	$626,073,100
2013-14 **	4	455,450	2.86	$138.28	$395.00	$539,711,800
2013-14 **	TOTAL	541,620	3.01	$125.71	$378.98	$2,463,183,100
2014-15 **	1	563,760	3.27	$142.21	$464.45	$785,512,600
2014-15 **	2	529,390	3.02	$142.90	$431.07	$684,626,400
2014-15 **	3	531,190	2.97	$143.29	$425.64	$678,297,000
2014-15 **	4	454,770	2.85	$146.87	$418.95	$571,589,700
2014-15 **	TOTAL	519,780	3.04	$143.61	$436.08	$2,720,025,600

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of prescriptions

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	5,760	5.61	$1,563.89	$8,777.52	$151,570,200
2012-13 *	4	4,790	5.42	$1,605.73	$8,697.94	$124,972,100
2012-13 *	TOTAL	5,940	5.76	$1,571.85	$9,047.62	$644,923,700
2013-14 *	1	4,740	5.36	$1,640.26	$8,787.36	$124,982,700
2013-14 *	2	4,530	5.31	$1,620.57	$8,602.67	$117,013,600
2013-14 **	3	4,690	5.63	$1,674.07	$9,418.67	$132,435,300
2013-14 **	4	3,780	5.63	$1,701.60	$9,583.01	$108,701,100
2013-14 **	TOTAL	4,440	5.47	$1,658.01	$9,076.49	$483,132,600
2014-15 **	1	4,720	5.74	$1,715.55	$9,855.05	$139,638,300
2014-15 **	2	4,490	5.55	$1,704.84	$9,467.42	$127,510,800
2014-15 **	3	4,650	5.53	$1,705.34	$9,430.31	$131,412,100
2014-15 **	4	3,780	5.64	$1,707.33	$9,626.04	$109,189,100
2014-15 **	TOTAL	4,410	5.62	$1,708.44	$9,595.44	$507,750,300

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	44,360	3.43	$2,036.75	$6,981.65	$929,103,800
2012-13 *	4	37,680	3.51	$2,023.41	$7,111.18	$803,918,300
2012-13 *	TOTAL	42,870	3.44	$2,026.75	$6,965.87	$3,583,126,100
2013-14 *	1	47,080	3.73	$1,937.94	$7,235.75	$1,021,912,800
2013-14 *	2	42,510	3.62	$1,847.91	$6,691.33	$853,378,200
2013-14 **	3	44,370	3.87	$1,885.66	$7,301.68	$971,899,200
2013-14 **	4	38,130	3.85	$1,888.26	$7,263.55	$830,929,400
2013-14 **	TOTAL	43,020	3.77	$1,891.46	$7,124.42	$3,678,119,700
2014-15 **	1	47,860	3.95	$1,916.76	$7,567.50	$1,086,549,600
2014-15 **	2	42,190	3.87	$1,900.89	$7,348.88	$930,102,000
2014-15 **	3	43,720	3.86	$1,917.47	$7,399.10	$970,530,400
2014-15 **	4	37,950	3.84	$1,921.10	$7,384.69	$840,835,500
2014-15 **	TOTAL	42,930	3.88	$1,914.01	$7,430.51	$3,828,017,500

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	$5,717.65	$1,065,392,900
2012-13 *	4	55,030	27.33	$182.75	$4,993.96	$824,468,600
2012-13 *	TOTAL	60,700	30.77	$185.71	$5,713.66	$4,161,958,800
2013-14 *	1	64,340	36.90	$180.35	$6,654.73	$1,284,555,500
2013-14 *	2	61,930	31.49	$182.49	$5,747.29	$1,067,841,000
2013-14 **	3	60,730	31.04	$181.29	$5,627.40	$1,025,200,300
2013-14 **	4	60,420	28.12	$183.27	$5,153.93	$934,151,300
2013-14 **	TOTAL	61,850	31.96	$181.73	$5,808.96	$4,311,748,000
2014-15 **	1	63,020	35.61	$182.28	$6,490.85	$1,227,234,800
2014-15 **	2	61,510	31.56	$182.80	$5,768.69	$1,064,420,500
2014-15 **	3	60,790	31.35	$181.81	$5,699.49	$1,039,454,400
2014-15 **	4	60,390	28.10	$183.22	$5,148.89	$932,859,200
2014-15 **	TOTAL	61,430	31.70	$182.50	$5,784.46	$4,263,969,000

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	$182.85	$5,165.40	$76,561,600
2012-13 *	TOTAL	5,330	30.82	$182.07	$5,611.31	$358,899,100
2013-14 *	1	5,400	36.26	$193.27	$7,008.76	$113,485,900
2013-14 *	2	5,220	31.37	$178.43	$5,597.81	$87,734,500
2013-14 **	3	5,190	30.81	$179.37	$5,526.56	$86,083,600
2013-14 **	4	5,180	26.62	$180.62	$4,807.37	$74,769,000
2013-14 **	TOTAL	5,250	31.32	$183.54	$5,747.71	$362,073,000
2014-15 **	1	5,240	36.17	$180.75	$6,537.05	$102,712,700
2014-15 **	2	5,230	31.49	$180.05	$5,669.85	$88,889,600
2014-15 **	3	5,210	30.66	$180.03	$5,519.96	$86,309,300
2014-15 **	4	5,210	26.63	$180.55	$4,808.23	$75,113,600
2014-15 **	TOTAL	5,220	31.24	$180.35	$5,635.08	$353,025,200

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of days stay

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	38,270	3.48	$93.44	$324.86	$37,296,200
2012-13 *	4	34,350	3.31	$93.79	$310.14	$31,961,300
2012-13 *	TOTAL	36,790	3.52	$93.82	$329.87	$145,648,800
2013-14 *	1	38,690	3.93	$93.20	$366.55	$42,549,700
2013-14 *	2	34,170	3.81	$83.96	$320.26	$32,829,600
2013-14 **	3	37,300	3.69	$80.60	$297.41	$33,283,100
2013-14 **	4	32,220	3.60	$84.66	$304.54	$29,439,800
2013-14 **	TOTAL	35,600	3.76	$85.87	$323.29	$138,102,200
2014-15 **	1	38,850	4.16	$84.36	$351.35	$40,954,400
2014-15 **	2	34,130	3.95	$82.03	$324.25	$33,200,700
2014-15 **	3	37,170	3.76	$82.00	$308.60	$34,409,100
2014-15 **	4	32,120	3.66	$84.55	$309.84	$29,860,400
2014-15 **	TOTAL	35,570	3.90	$83.24	$324.31	$138,424,500

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	179,900	3.04	$100.45	$305.34	$164,790,800
2012-13 *	4	214,380	3.48	$74.12	$257.86	$165,840,500
2012-13 *	TOTAL	202,320	3.15	$102.63	$322.77	$783,633,500
2013-14 *	1	216,820	3.42	$96.81	$330.88	$215,227,700
2013-14 *	2	217,900	3.25	$86.75	$281.69	$184,138,500
2013-14 **	3	228,850	3.16	$82.98	$262.56	$180,256,800
2013-14 **	4	229,280	3.50	$74.80	$261.70	$180,005,900
2013-14 **	TOTAL	223,210	3.33	$85.12	$283.60	$759,628,900
2014-15 **	1	229,310	3.71	$88.73	$329.23	$226,484,800
2014-15 **	2	216,740	3.40	$84.17	$286.19	$186,086,600
2014-15 **	3	222,810	3.42	$83.62	$286.04	$191,195,500
2014-15 **	4	226,510	3.71	$75.18	$279.18	$189,712,100
2014-15 **	TOTAL	223,840	3.56	$82.89	$295.40	$793,478,900

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY OF FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY SERVICE CATEGORY (INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	$1,288.25	$3,719.98	$55,717,900
2012-13 *	4	4,370	2.88	$1,300.14	$3,742.71	$49,025,700
2012-13 *	TOTAL	4,820	2.90	$1,318.38	$3,818.56	$220,716,800
2013-14 *	1	4,730	3.50	$1,384.39	$4,847.43	$68,794,700
2013-14 *	2	4,570	3.16	$1,336.48	$4,228.10	$57,937,600
2013-14 **	3	4,780	3.21	$1,314.05	$4,218.62	$60,497,800
2013-14 **	4	4,290	3.20	$1,330.76	$4,257.87	$54,850,300
2013-14 **	TOTAL	4,590	3.27	$1,342.65	$4,392.06	$242,080,400
2014-15 **	1	4,680	3.77	$1,390.81	$5,243.48	$73,684,400
2014-15 **	2	4,550	3.42	$1,367.22	$4,676.02	$63,792,300
2014-15 **	3	4,770	3.47	$1,321.51	$4,582.30	$65,615,300
2014-15 **	4	4,290	3.45	$1,336.77	$4,609.71	$59,382,700
2014-15 **	TOTAL	4,570	3.53	$1,354.97	$4,781.27	$262,474,700

* ACTUAL
** ESTIMATED
NOTE: UNITS = Number of claims

QUARTERLY SUMMARY
OF
FEE FOR SERVICE UTILIZATION AND EXPENDITURES BY AID CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	154,330	4.91	$128.92	$633.40	$293,267,400
2013-14 *	2	142,410	4.51	$118.10	$533.18	$227,797,200
2013-14 **	3	151,300	4.43	$114.02	$505.20	$229,313,300
2013-14 **	4	132,560	4.40	$119.47	$525.21	$208,866,900
2013-14 **	TOTAL	145,150	4.57	$120.46	$550.71	$959,244,900
2014-15 **	1	148,270	5.13	$117.61	$603.69	$268,533,200
2014-15 **	2	138,170	4.61	$117.30	$540.38	$223,998,900
2014-15 **	3	146,870	4.56	$117.09	$534.25	$235,401,600
2014-15 **	4	131,610	4.44	$120.07	$532.52	$210,258,500
2014-15 **	TOTAL	141,230	4.69	$117.95	$553.57	$938,192,200

* 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 MAY 2014 BASE ESTIMATES)

PA-AB

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	7.85	$173.06	$1,357.77	$32,895,900
2013-14 *	2	7,570	7.19	$167.71	$1,206.38	$27,409,000
2013-14 **	3	7,770	6.84	$171.80	$1,175.00	$27,403,900
2013-14 **	4	7,090	6.63	$172.10	$1,140.87	$24,264,400
2013-14 **	TOTAL	7,630	7.14	$171.21	$1,223.23	$111,973,300
2014-15 **	1	7,870	8.03	$172.72	$1,387.29	$32,763,700
2014-15 **	2	7,390	7.20	$173.57	$1,249.28	$27,714,200
2014-15 **	3	7,550	7.08	$176.22	$1,247.47	$28,236,900
2014-15 **	4	6,990	6.71	$176.50	$1,183.75	$24,818,400
2014-15 **	TOTAL	7,450	7.27	$174.61	$1,269.91	$113,533,300

* 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 MAY 2014 BASE ESTIMATES)

PA-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	366,230	6.01	$197.21	$1,185.38	$1,302,360,300
2013-14 *	2	341,280	5.39	$189.99	$1,023.60	$1,048,003,900
2013-14 **	3	349,410	5.24	$196.70	$1,031.42	$1,081,156,800
2013-14 **	4	328,880	5.07	$193.58	$981.68	$968,570,500
2013-14 **	TOTAL	346,450	5.44	$194.52	$1,058.38	$4,400,091,500
2014-15 **	1	363,290	6.02	$201.94	$1,216.51	$1,325,846,700
2014-15 **	2	337,390	5.47	$202.41	$1,106.86	$1,120,325,000
2014-15 **	3	340,140	5.44	$202.56	$1,101.18	$1,123,680,400
2014-15 **	4	323,120	5.18	$197.60	$1,023.31	$991,954,200
2014-15 **	TOTAL	340,990	5.54	$201.24	$1,114.86	$4,561,806,300

* 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 MAY 2014 BASE ESTIMATES)

PA-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	187,230	2.53	$163.45	$413.72	$232,379,200
2013-14 *	2	176,070	2.33	$156.09	$363.01	$191,740,000
2013-14 **	3	170,790	2.29	$170.14	$389.88	$199,763,500
2013-14 **	4	151,280	2.33	$160.44	$374.61	$170,016,600
2013-14 **	TOTAL	171,340	2.38	$162.55	$386.12	$793,899,300
2014-15 **	1	174,930	2.41	$177.61	$427.57	$224,389,400
2014-15 **	2	167,020	2.27	$173.50	$394.37	$197,610,200
2014-15 **	3	168,460	2.36	$172.96	$408.04	$206,215,700
2014-15 **	4	153,340	2.34	$162.99	$381.94	$175,696,100
2014-15 **	TOTAL	165,940	2.35	$172.05	$403.72	$803,911,400

* 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 AID CATEGORY (INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	36,450	35.94	$161.53	$5,804.94	$634,683,100
2013-14 *	2	35,300	30.41	$162.36	$4,937.91	$522,973,900
2013-14 **	3	34,400	30.14	$159.28	$4,800.28	$495,426,900
2013-14 **	4	32,700	28.06	$162.88	$4,570.62	$448,428,800
2013-14 **	TOTAL	34,710	31.24	$161.49	$5,044.87	$2,101,512,800
2014-15 **	1	35,310	34.77	$162.67	$5,655.58	$599,016,900
2014-15 **	2	34,660	30.64	$162.28	$4,972.23	$517,023,300
2014-15 **	3	34,300	30.65	$160.42	$4,916.79	$505,971,700
2014-15 **	4	32,730	28.05	$162.94	$4,570.11	$448,700,000
2014-15 **	TOTAL	34,250	31.09	$162.08	$5,038.39	$2,070,712,000

* 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 MAY 2014 BASE ESTIMATES)

LT-AB

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	37.01	$172.23	$6,374.40	$3,748,100
2013-14 *	2	190	31.34	$165.76	$5,194.55	$3,023,200
2013-14 **	3	200	31.79	$163.74	$5,205.64	$3,066,300
2013-14 **	4	190	27.59	$163.12	$4,500.94	$2,556,000
2013-14 **	TOTAL	190	31.97	$166.59	$5,326.23	$12,393,600
2014-15 **	1	200	34.96	$158.49	$5,540.05	$3,357,100
2014-15 **	2	200	30.73	$168.27	$5,171.23	$3,115,200
2014-15 **	3	200	30.66	$165.24	$5,065.82	$3,052,200
2014-15 **	4	190	27.18	$162.73	$4,422.27	$2,554,400
2014-15 **	TOTAL	200	30.92	$163.53	$5,057.08	$12,078,900

* 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 MAY 2014 BASE ESTIMATES)

LT-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	11,610	36.69	$197.44	$7,244.64	$252,265,500
2013-14 *	2	11,360	32.08	$196.56	$6,304.71	$214,814,100
2013-14 **	3	11,050	31.19	$199.64	$6,227.46	$206,435,400
2013-14 **	4	10,840	28.28	$201.59	$5,701.25	$185,438,200
2013-14 **	TOTAL	11,210	32.14	$198.63	$6,383.04	$858,953,200
2014-15 **	1	11,560	35.45	$197.16	$6,990.15	$242,337,600
2014-15 **	2	11,330	31.75	$199.39	$6,330.22	$215,162,400
2014-15 **	3	11,190	31.19	$198.86	$6,202.67	$208,271,300
2014-15 **	4	10,890	28.18	$201.59	$5,680.76	$185,505,400
2014-15 **	TOTAL	11,240	31.70	$199.09	$6,310.86	$851,276,800

* 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 MAY 2014 BASE ESTIMATES)

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2011-12 *	1	0		$0.00	$0.00	$0
2011-12 *	2	0		$0.00	$0.00	$0
2011-12 *	3	0		$0.00	$0.00	$0
2011-12 *	4	0		$0.00	$0.00	$0
2011-12 *	TOTAL	0		$0.00	$0.00	$0
2012-13 *	1	0		$0.00	$0.00	$0
2012-13 *	2	0		$0.00	$0.00	$0
2012-13 *	3	4,930	2.40	$99.30	$238.31	$3,524,300
2012-13 *	4	26,800	2.42	$113.83	$275.48	$22,150,400
2012-13 *	TOTAL	7,930	2.42	$111.59	$269.70	$25,674,700
2013-14 *	1	49,380	2.34	$137.86	$322.89	$47,834,500
2013-14 *	2	59,680	2.37	$126.20	$298.75	$53,491,100
2013-14 **	3	60,790	2.35	$149.70	$351.17	$64,040,300
2013-14 **	4	51,380	2.79	$141.08	$393.24	$60,609,500
2013-14 **	TOTAL	55,310	2.45	$138.78	$340.49	$225,975,400
2014-15 **	1	62,720	2.43	$142.34	$346.32	$65,157,900
2014-15 **	2	61,970	2.57	$136.66	$350.65	$65,194,900
2014-15 **	3	59,660	2.41	$144.42	$347.93	$62,272,100
2014-15 **	4	53,770	2.76	$140.63	$388.39	$62,646,200
2014-15 **	TOTAL	59,530	2.54	$140.92	$357.35	$255,271,100

* 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 MAY 2014 BASE ESTIMATES)

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	81,640	4.96	$143.18	$710.80	$174,095,800
2013-14 *	2	76,440	4.56	$132.48	$604.46	$138,616,900
2013-14 **	3	79,130	4.49	$133.88	$600.78	$142,614,100
2013-14 **	4	71,630	4.35	$136.63	$593.70	$127,573,300
2013-14 **	TOTAL	77,210	4.60	$136.79	$629.13	$582,900,100
2014-15 **	1	82,220	5.00	$135.54	$677.34	$167,073,600
2014-15 **	2	77,130	4.51	$134.34	$605.32	$140,067,600
2014-15 **	3	79,910	4.48	$133.88	$599.48	$143,716,700
2014-15 **	4	73,570	4.30	$136.21	$585.78	$129,285,000
2014-15 **	TOTAL	78,210	4.58	$134.98	$618.16	$580,143,000

* 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 MAY 2014 BASE ESTIMATES)

MN-AB

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	240	8.39	$223.41	$1,874.88	$1,348,000
2013-14 *	2	220	8.51	$251.34	$2,137.72	$1,425,900
2013-14 **	3	200	8.84	$233.83	$2,066.77	$1,246,400
2013-14 **	4	220	8.39	$212.50	$1,782.86	$1,156,100
2013-14 **	TOTAL	220	8.52	$230.29	$1,962.60	$5,176,400
2014-15 **	1	260	8.99	$207.49	$1,865.46	$1,455,400
2014-15 **	2	240	8.32	$204.88	$1,705.22	$1,241,400
2014-15 **	3	240	8.47	$226.12	$1,915.02	$1,364,500
2014-15 **	4	240	8.05	$211.02	$1,699.57	$1,203,100
2014-15 **	TOTAL	240	8.47	$212.19	$1,797.59	$5,264,400

* 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 AID CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

MN-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	68,590	6.22	$253.95	$1,580.78	$325,256,300
2013-14 *	2	64,300	5.66	$246.10	$1,392.00	$268,522,900
2013-14 **	3	65,710	5.54	$253.56	$1,405.56	$277,080,200
2013-14 **	4	61,180	5.52	$238.03	$1,314.64	$241,280,100
2013-14 **	TOTAL	64,940	5.75	$248.34	$1,427.05	$1,112,139,600
2014-15 **	1	68,670	6.56	$245.82	$1,613.84	$332,485,900
2014-15 **	2	65,580	5.73	$249.29	$1,429.20	$281,160,800
2014-15 **	3	67,370	5.69	$248.54	$1,413.95	$285,766,600
2014-15 **	4	64,170	5.60	$236.15	$1,322.45	$254,588,900
2014-15 **	TOTAL	66,450	5.90	$245.10	$1,447.27	$1,154,002,200

* 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 MAY 2014 BASE ESTIMATES)

MN-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	500,460	2.88	$188.84	$543.08	$815,371,900
2013-14 *	2	460,270	2.63	$186.75	$490.36	$677,095,500
2013-14 **	3	436,650	2.61	$207.71	$542.16	$710,199,500
2013-14 **	4	375,300	2.71	$203.70	$551.36	$620,774,400
2013-14 **	TOTAL	443,170	2.71	$195.93	$530.92	$2,823,441,300
2014-15 **	1	434,600	2.94	$213.88	$629.59	$820,873,200
2014-15 **	2	398,570	2.74	$215.67	$591.93	$707,777,400
2014-15 **	3	397,330	2.80	$215.31	$601.85	$717,404,500
2014-15 **	4	362,980	2.76	$207.72	$574.20	$625,262,700
2014-15 **	TOTAL	398,370	2.82	$213.29	$600.64	$2,871,317,900

* 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 MAY 2014 BASE ESTIMATES)

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	83,170	2.73	$144.83	$394.76	$98,498,700
2013-14 *	2	77,500	2.64	$140.69	$370.74	$86,195,000
2013-14 **	3	97,950	2.76	$138.98	$383.68	$112,742,000
2013-14 **	4	76,830	2.51	$149.21	$373.85	$86,173,000
2013-14 **	TOTAL	83,860	2.66	$143.06	$381.19	$383,608,700
2014-15 **	1	85,160	2.70	$147.17	$396.89	$101,397,500
2014-15 **	2	76,920	2.68	$147.66	$395.51	$91,266,900
2014-15 **	3	73,870	2.73	$150.00	$409.58	$90,770,400
2014-15 **	4	67,400	2.67	$146.74	$391.30	$79,123,600
2014-15 **	TOTAL	75,840	2.69	$147.90	$398.39	$362,558,400

* 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 AID CATEGORY (INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

MI-A

YEAR	QUARTER	AVERAGE MONTHLY USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	1,770	16.71	$199.00	$3,325.21	$17,663,500
2013-14 *	2	1,710	11.88	$190.40	$2,262.63	$11,614,100
2013-14 **	3	1,500	13.73	$206.27	$2,832.38	$12,746,800
2013-14 **	4	1,460	14.62	$196.87	$2,877.37	$12,603,700
2013-14 **	TOTAL	1,610	14.26	$198.23	$2,826.71	$54,628,100
2014-15 **	1	1,720	15.85	$200.17	$3,173.21	$16,406,700
2014-15 **	2	1,580	15.15	$198.66	$3,008.94	$14,287,200
2014-15 **	3	1,520	14.61	$201.40	$2,941.88	$13,421,500
2014-15 **	4	1,480	14.58	$195.94	$2,856.04	$12,697,700
2014-15 **	TOTAL	1,580	15.08	$199.11	$3,001.73	$56,813,200

* 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 MAY 2014 BASE ESTIMATES)

REFUGEE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	840	2.82	$197.90	$558.89	$1,405,100
2013-14 *	2	630	2.78	$145.04	$402.95	$764,800
2013-14 **	3	690	2.49	$135.43	$336.81	$696,500
2013-14 **	4	760	2.39	$150.28	$358.78	$813,900
2013-14 **	TOTAL	730	2.62	$160.49	$420.67	$3,680,300
2014-15 **	1	920	2.61	$129.16	$336.64	$932,700
2014-15 **	2	840	2.78	$145.03	$402.78	$1,009,800
2014-15 **	3	930	2.43	$131.01	$318.41	$886,200
2014-15 **	4	850	2.38	$145.12	$345.51	$883,700
2014-15 **	TOTAL	880	2.55	$137.30	$349.61	$3,712,400

* 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 AID CATEGORY
(INCLUDES ACTUALS AND MAY 2014 BASE ESTIMATES)

OBRA

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	15,160	5.96	$246.29	$1,468.39	$66,776,500
2013-14 *	2	14,610	5.66	$244.88	$1,385.79	$60,734,900
2013-14 **	3	18,850	5.51	$236.39	$1,302.88	$73,686,600
2013-14 **	4	24,460	5.09	$201.09	$1,023.20	$75,087,400
2013-14 **	TOTAL	18,270	5.49	$229.42	$1,260.17	$276,285,400
2014-15 **	1	28,560	5.51	$201.99	$1,112.71	$95,334,300
2014-15 **	2	28,360	5.19	$194.21	$1,008.23	$85,788,900
2014-15 **	3	28,580	5.07	$199.59	$1,010.96	$86,689,600
2014-15 **	4	27,350	4.89	$198.93	$972.18	$79,757,300
2014-15 **	TOTAL	28,210	5.17	$198.73	$1,026.63	$347,570,000

* 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 MAY 2014 BASE ESTIMATES)

POV 185

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	132,040	3.57	$187.10	$668.77	$264,920,600
2013-14 *	2	126,050	3.41	$183.48	$625.09	$236,381,300
2013-14 **	3	123,220	3.50	$198.64	$695.79	$257,203,500
2013-14 **	4	114,710	3.25	$188.30	$611.85	$210,565,900
2013-14 **	TOTAL	124,010	3.44	$189.37	$651.22	$969,071,300
2014-15 **	1	137,710	3.57	$183.96	$657.23	$271,524,800
2014-15 **	2	127,060	3.45	$190.08	$655.48	$249,863,900
2014-15 **	3	130,480	3.42	$192.24	$657.47	$257,349,800
2014-15 **	4	120,560	3.18	$187.58	$597.40	$216,066,300
2014-15 **	TOTAL	128,950	3.41	$188.37	$642.87	$994,804,900

* 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 MAY 2014 BASE ESTIMATES)

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	21,310	2.03	$134.67	$273.45	$17,484,500
2013-14 *	2	19,930	1.95	$131.99	$257.54	$15,394,500
2013-14 **	3	19,050	2.01	$130.98	$263.32	$15,050,200
2013-14 **	4	16,090	2.12	$128.00	$271.04	$13,082,000
2013-14 **	TOTAL	19,090	2.02	$131.61	$266.26	$61,011,200
2014-15 **	1	18,880	2.06	$139.93	$287.86	$16,301,600
2014-15 **	2	17,710	1.99	$137.53	$273.76	$14,548,400
2014-15 **	3	17,500	2.13	$136.46	$290.81	$15,267,300
2014-15 **	4	15,380	2.16	$131.54	$284.63	$13,135,900
2014-15 **	TOTAL	17,370	2.08	$136.52	$284.29	$59,253,200

* 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 MAY 2014 BASE ESTIMATES)

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
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	21,580	2.37	$151.37	$358.87	$23,236,000
2013-14 *	2	21,150	2.27	$149.54	$339.07	$21,511,000
2013-14 **	3	20,940	2.21	$143.08	$316.06	$19,855,000
2013-14 **	4	20,620	2.29	$132.38	$302.99	$18,741,000
2013-14 **	TOTAL	21,070	2.28	$144.27	$329.60	$83,342,900
2014-15 **	1	24,080	2.29	$153.36	$351.57	$25,398,900
2014-15 **	2	22,260	2.19	$155.01	$339.42	$22,661,900
2014-15 **	3	21,240	2.24	$151.82	$340.77	$21,709,800
2014-15 **	4	20,240	2.31	$137.76	$318.11	$19,311,000
2014-15 **	TOTAL	21,950	2.26	$149.72	$338.17	$89,081,600

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

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL			
62	NARCOTIC TREATMENT PROGRAM	$28,878,000	$28,878,000	$0
63	RESIDENTIAL TREATMENT SERVICES	$875,000	$875,000	$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$18,915,000	$18,915,000	$0
65	INTENSIVE OUTPATIENT TREATMENT SERVICES	$29,190,000	$21,006,000	$8,184,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,050,000	-$27,050,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$50,808,000**	**$42,624,000**	**$8,184,000**
	MENTAL HEALTH			
69	SMHS FOR CHILDREN	$827,218,000	$827,218,000	$0
70	SMHS FOR ADULTS	$549,275,000	$549,275,000	$0
	MENTAL HEALTH SUBTOTAL	**$1,376,493,000**	**$1,376,493,000**	**$0**
	MANAGED CARE			
114	TWO PLAN MODEL	$8,234,423,000	$4,199,168,850	$4,035,254,150
115	COUNTY ORGANIZED HEALTH SYSTEMS	$4,134,702,000	$2,106,113,950	$2,028,588,050
116	GEOGRAPHIC MANAGED CARE	$1,379,583,000	$706,114,050	$673,468,950
122	PACE (Other M/C)	$193,351,000	$96,675,500	$96,675,500
125	DENTAL MANAGED CARE (Other M/C)	$66,037,000	$33,018,500	$33,018,500
126	SENIOR CARE ACTION NETWORK (Other M/C)	$41,110,000	$20,555,000	$20,555,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	$9,582,000	$4,791,000	$4,791,000
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,510,000	$755,000	$755,000
215	REGIONAL MODEL	$182,120,000	$93,590,800	$88,529,200
	MANAGED CARE SUBTOTAL	**$14,242,418,000**	**$7,260,782,650**	**$6,981,635,350**
	OTHER			
171	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,859,585,000	$2,859,585,000	$0
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,491,279,000	$1,163,665,000	$1,327,614,000
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,475,883,000	$0	$1,475,883,000
174	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,251,086,000	$1,251,086,000	$0
175	DENTAL SERVICES	$548,562,000	$292,504,350	$256,057,650
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$261,000,000	$261,000,000	$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$157,313,000	$157,313,000	$0
180	MEDI-CAL TCM PROGRAM	$45,290,000	$45,290,000	$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$26,039,000	$13,019,500	$13,019,500
182	EPSDT SCREENS	$37,871,000	$19,834,300	$18,036,700
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,384,000	$1,192,000	$1,192,000
189	LAWSUITS/CLAIMS	$2,555,000	$1,277,500	$1,277,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,799,000	$1,799,000	$0
202	BASE RECOVERIES	-$312,935,000	-$155,422,000	-$157,513,000
	OTHER SUBTOTAL	**$8,847,711,000**	**$5,912,143,650**	**$2,935,567,350**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	GRAND TOTAL	$24,517,430,000	$14,592,043,300	$9,925,386,700

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL			
62	NARCOTIC TREATMENT PROGRAM	$24,584,000	$24,584,000	$0
63	RESIDENTIAL TREATMENT SERVICES	$111,421,000	$74,507,000	$36,914,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$26,379,000	$26,379,000	$0
65	INTENSIVE OUTPATIENT TREATMENT SERVICES	$66,590,000	$46,269,000	$20,321,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,050,000	-$27,050,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$201,924,000**	**$144,689,000**	**$57,235,000**
	MENTAL HEALTH			
69	SMHS FOR CHILDREN	$875,642,000	$875,642,000	$0
70	SMHS FOR ADULTS	$565,334,000	$565,334,000	$0
	MENTAL HEALTH SUBTOTAL	**$1,440,976,000**	**$1,440,976,000**	**$0**
	MANAGED CARE			
114	TWO PLAN MODEL	$8,792,854,000	$4,482,965,750	$4,309,888,250
115	COUNTY ORGANIZED HEALTH SYSTEMS	$4,307,708,000	$2,195,130,100	$2,112,577,900
116	GEOGRAPHIC MANAGED CARE	$1,619,755,000	$827,168,400	$792,586,600
122	PACE (Other M/C)	$243,791,000	$121,895,500	$121,895,500
125	DENTAL MANAGED CARE (Other M/C)	$67,103,000	$33,551,500	$33,551,500
126	SENIOR CARE ACTION NETWORK (Other M/C)	$41,232,000	$20,616,000	$20,616,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	$9,061,000	$4,530,500	$4,530,500
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,442,000	$721,000	$721,000
215	REGIONAL MODEL	$300,253,000	$154,833,800	$145,419,200
	MANAGED CARE SUBTOTAL	**$15,383,199,000**	**$7,841,412,550**	**$7,541,786,450**
	OTHER			
171	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,259,927,000	$3,259,927,000	$0
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,575,216,000	$1,202,258,500	$1,372,957,500
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,462,530,000	$0	$1,462,530,000
174	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,406,132,000	$1,406,132,000	$0
175	DENTAL SERVICES	$578,288,000	$310,977,100	$267,310,900
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$265,000,000	$265,000,000	$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$158,421,000	$158,421,000	$0
180	MEDI-CAL TCM PROGRAM	$44,554,000	$44,554,000	$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$32,158,000	$16,079,000	$16,079,000
182	EPSDT SCREENS	$38,799,000	$20,320,350	$18,478,650
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,478,000	$1,239,000	$1,239,000
189	LAWSUITS/CLAIMS	$7,865,000	$3,932,500	$3,932,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,285,000	$1,285,000	$0
202	BASE RECOVERIES	-$266,285,000	-$132,253,000	-$134,032,000
	OTHER SUBTOTAL	**$9,566,368,000**	**$6,557,872,450**	**$3,008,495,550**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	GRAND TOTAL	**$26,592,467,000**	**$15,984,950,000**	**$10,607,517,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS
	DRUG MEDI-CAL							
57	NALTREXONE TREATMENT SERVICES	$0	$0	$0	$0	$0	$0	$0
62	NARCOTIC TREATMENT PROGRAM	$61,500,000	$0	$55,944,000	$0	$28,878,000	$0	-$32,622,000
63	RESIDENTIAL TREATMENT SERVICES	$718,000	$0	$53,270,000	$21,016,000	$875,000	$0	$157,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$23,490,000	$0	$27,084,000	$0	$18,915,000	$0	-$4,575,000
65	INTENSIVE OUTPATIENT TREATMENT SERVICES	$9,563,000	$0	$32,160,000	$7,823,000	$29,190,000	$8,184,000	$19,627,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	$0	$0	-$14,650,000	$0	-$27,050,000	$0	-$27,050,000
	DRUG MEDI-CAL SUBTOTAL	**$95,271,000**	**$0**	**$153,808,000**	**$28,839,000**	**$50,808,000**	**$8,184,000**	**-$44,463,000**
	MENTAL HEALTH							
69	SMHS FOR CHILDREN	$775,685,000	$0	$728,307,000	$0	$827,218,000	$0	$51,533,000
70	SMHS FOR ADULTS	$515,510,000	$0	$502,241,000	$0	$549,275,000	$0	$33,765,000
	MENTAL HEALTH SUBTOTAL	**$1,291,195,000**	**$0**	**$1,230,548,000**	**$0**	**$1,376,493,000**	**$0**	**$85,298,000**
	MANAGED CARE							
114	TWO PLAN MODEL	$7,499,108,000	$3,734,834,800	$7,520,181,000	$3,743,332,500	$8,234,423,000	$4,035,254,150	$735,315,000
115	COUNTY ORGANIZED HEALTH SYSTEMS	$3,384,466,000	$1,685,228,800	$3,567,054,000	$1,777,061,500	$4,134,702,000	$2,028,588,050	$750,236,000
116	GEOGRAPHIC MANAGED CARE	$1,288,011,000	$641,352,200	$1,273,660,000	$634,729,500	$1,379,583,000	$673,468,950	$91,572,000
122	PACE (Other M/C)	$220,893,000	$110,446,500	$196,190,000	$98,095,000	$193,351,000	$96,675,500	-$27,542,000
125	DENTAL MANAGED CARE (Other M/C)	$48,801,000	$24,400,500	$49,050,000	$24,525,000	$66,037,000	$33,018,500	$17,236,000
126	SENIOR CARE ACTION NETWORK (Other M/C)	$24,100,000	$12,050,000	$40,158,000	$20,079,000	$41,110,000	$20,555,000	$17,010,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	$12,526,000	$6,263,000	$4,320,000	$2,160,000	$9,582,000	$4,791,000	-$2,944,000
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$2,915,000	$1,457,500	$2,597,000	$1,298,500	$1,510,000	$755,000	-$1,405,000
215	REGIONAL MODEL	$0	$0	$0	$0	$182,120,000	$88,529,200	$182,120,000
	MANAGED CARE SUBTOTAL	**$12,480,820,000**	**$6,216,033,300**	**$12,653,210,000**	**$6,301,281,000**	**$14,242,418,000**	**$6,981,635,350**	**$1,761,598,000**
	OTHER							
171	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,697,294,000	$0	$2,695,250,000	$0	$2,859,585,000	$0	$162,291,000
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	$2,491,279,000	$1,327,614,000	-$72,046,000
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,481,141,000	$1,481,141,000	$1,474,761,000	$1,474,761,000	$1,475,883,000	$1,475,883,000	-$5,258,000
174	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,286,515,000	$0	$1,236,319,000	$0	$1,251,086,000	$0	-$35,429,000
175	DENTAL SERVICES	$506,023,000	$249,060,650	$498,146,000	$238,978,600	$548,562,000	$256,057,650	$42,539,000

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS
	OTHER							
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$236,509,000	$0	$258,500,000	$0	$261,000,000	$0	$24,491,000
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$159,939,000	$0	$145,524,000	$0	$157,313,000	$0	-$2,626,000
180	MEDI-CAL TCM PROGRAM	$47,845,000	$0	$45,290,000	$0	$45,290,000	$0	-$2,555,000
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$40,674,000	$20,337,000	$37,199,000	$18,599,500	$26,039,000	$13,019,500	-$14,635,000
182	EPSDT SCREENS	$42,448,000	$21,224,000	$38,733,000	$19,222,200	$37,871,000	$18,036,700	-$4,577,000
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,255,000	$1,127,500	$2,446,000	$1,223,000	$2,384,000	$1,192,000	$129,000
189	LAWSUITS/CLAIMS	$1,865,000	$932,500	$2,496,000	$1,248,000	$2,555,000	$1,277,500	$690,000
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,285,000	$0	$1,799,000	$0	$1,799,000	$0	$514,000
202	BASE RECOVERIES	-$251,766,000	-$149,340,000	-$262,270,000	-$132,011,000	-$312,935,000	-$157,513,000	-$61,169,000
	OTHER SUBTOTAL	**$8,815,352,000**	**$2,989,542,650**	**$8,737,020,000**	**$2,985,515,800**	**$8,847,711,000**	**$2,935,567,350**	**$32,359,000**
	GRAND TOTAL	**$22,682,638,000**	**$9,205,575,950**	**$22,774,586,000**	**$9,315,635,800**	**$24,517,430,000**	**$9,925,386,700**	**$1,834,792,000**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL				
62	NARCOTIC TREATMENT PROGRAM	$57,938,000	$0	$24,584,000	$0
63	RESIDENTIAL TREATMENT SERVICES	$128,030,000	$50,344,000	$111,421,000	$36,914,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$31,226,000	$0	$26,379,000	$0
65	INTENSIVE OUTPATIENT TREATMENT SERVICES	$61,300,000	$18,647,000	$66,590,000	$20,321,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$14,650,000	$0	-$27,050,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$263,844,000**	**$68,991,000**	**$201,924,000**	**$57,235,000**
	MENTAL HEALTH				
69	SMHS FOR CHILDREN	$758,674,000	$0	$875,642,000	$0
70	SMHS FOR ADULTS	$512,977,000	$0	$565,334,000	$0
	MENTAL HEALTH SUBTOTAL	**$1,271,651,000**	**$0**	**$1,440,976,000**	**$0**
	MANAGED CARE				
114	TWO PLAN MODEL	$7,847,249,000	$3,906,757,500	$8,792,854,000	$4,309,888,250
115	COUNTY ORGANIZED HEALTH SYSTEMS	$3,607,617,000	$1,797,114,100	$4,307,708,000	$2,112,577,900
116	GEOGRAPHIC MANAGED CARE	$1,357,157,000	$676,411,000	$1,619,755,000	$792,586,600
122	PACE (Other M/C)	$262,614,000	$131,307,000	$243,791,000	$121,895,500
125	DENTAL MANAGED CARE (Other M/C)	$49,710,000	$24,855,000	$67,103,000	$33,551,500
126	SENIOR CARE ACTION NETWORK (Other M/C)	$39,407,000	$19,703,500	$41,232,000	$20,616,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	$9,263,000	$4,631,500	$9,061,000	$4,530,500
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$2,708,000	$1,354,000	$1,442,000	$721,000
215	REGIONAL MODEL			$300,253,000	$145,419,200
	MANAGED CARE SUBTOTAL	**$13,175,725,000**	**$6,562,133,600**	**$15,383,199,000**	**$7,541,786,450**
	OTHER				
171	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,799,250,000	$0	$3,259,927,000	$0
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,701,309,000	$1,438,340,500	$2,575,216,000	$1,372,957,500
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,453,897,000	$1,453,897,000	$1,462,530,000	$1,462,530,000
174	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,297,385,000	$0	$1,406,132,000	$0
175	DENTAL SERVICES	$505,737,000	$242,774,100	$578,288,000	$267,310,900
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$263,000,000	$0	$265,000,000	$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$154,922,000	$0	$158,421,000	$0
180	MEDI-CAL TCM PROGRAM	$44,554,000	$0	$44,554,000	$0

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

		NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15	
NO.	**POLICY CHANGE TITLE**	**TOTAL FUNDS**	**STATE FUNDS**	**TOTAL FUNDS**	**STATE FUNDS**
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$37,899,000	$18,949,500	$32,158,000	$16,079,000
182	EPSDT SCREENS	$39,279,000	$19,493,250	$38,799,000	$18,478,650
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,571,000	$1,285,500	$2,478,000	$1,239,000
189	LAWSUITS/CLAIMS	$1,865,000	$932,500	$7,865,000	$3,932,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,285,000	$0	$1,285,000	$0
202	BASE RECOVERIES	-$255,248,000	-$128,477,000	-$266,285,000	-$134,032,000
	OTHER SUBTOTAL	**$9,047,705,000**	**$3,047,195,350**	**$9,566,368,000**	**$3,008,495,550**
	GRAND TOTAL	**$23,758,925,000**	**$9,678,319,950**	**$26,592,467,000**	**$10,607,517,000**

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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL				
62	NARCOTIC TREATMENT PROGRAM	$28,878,000	$0	$24,584,000	$0
63	RESIDENTIAL TREATMENT SERVICES	$875,000	$0	$111,421,000	$36,914,000
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$18,915,000	$0	$26,379,000	$0
65	INTENSIVE OUTPATIENT TREATMENT SERVICES	$29,190,000	$8,184,000	$66,590,000	$20,321,000
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,050,000	$0	-$27,050,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$50,808,000**	**$8,184,000**	**$201,924,000**	**$57,235,000**
	MENTAL HEALTH				
69	SMHS FOR CHILDREN	$827,218,000	$0	$875,642,000	$0
70	SMHS FOR ADULTS	$549,275,000	$0	$565,334,000	$0
	MENTAL HEALTH SUBTOTAL	**$1,376,493,000**	**$0**	**$1,440,976,000**	**$0**
	MANAGED CARE				
114	TWO PLAN MODEL	$8,234,423,000	$4,035,254,150	$8,792,854,000	$4,309,888,250
115	COUNTY ORGANIZED HEALTH SYSTEMS	$4,134,702,000	$2,028,588,050	$4,307,708,000	$2,112,577,900
116	GEOGRAPHIC MANAGED CARE	$1,379,583,000	$673,468,950	$1,619,755,000	$792,586,600
122	PACE (Other M/C)	$193,351,000	$96,675,500	$243,791,000	$121,895,500
125	DENTAL MANAGED CARE (Other M/C)	$66,037,000	$33,018,500	$67,103,000	$33,551,500
126	SENIOR CARE ACTION NETWORK (Other M/C)	$41,110,000	$20,555,000	$41,232,000	$20,616,000
129	AIDS HEALTHCARE CENTERS (Other M/C)	$9,582,000	$4,791,000	$9,061,000	$4,530,500
130	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,510,000	$755,000	$1,442,000	$721,000
215	REGIONAL MODEL	$182,120,000	$88,529,200	$300,253,000	$145,419,200
	MANAGED CARE SUBTOTAL	**$14,242,418,000**	**$6,981,635,350**	**$15,383,199,000**	**$7,541,786,450**
	OTHER				
171	PERSONAL CARE SERVICES (Misc. Svcs.)	$2,859,585,000	$0	$3,259,927,000	$0
172	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,491,279,000	$1,327,614,000	$2,575,216,000	$1,372,957,500
173	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,475,883,000	$1,475,883,000	$1,462,530,000	$1,462,530,000
174	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,251,086,000	$0	$1,406,132,000	$0
175	DENTAL SERVICES	$548,562,000	$256,057,650	$578,288,000	$267,310,900

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

		MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER				
176	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$261,000,000	$0	$265,000,000	$0
179	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$157,313,000	$0	$158,421,000	$0
180	MEDI-CAL TCM PROGRAM	$45,290,000	$0	$44,554,000	$0
181	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$26,039,000	$13,019,500	$32,158,000	$16,079,000
182	EPSDT SCREENS	$37,871,000	$18,036,700	$38,799,000	$18,478,650
188	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,384,000	$1,192,000	$2,478,000	$1,239,000
189	LAWSUITS/CLAIMS	$2,555,000	$1,277,500	$7,865,000	$3,932,500
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,799,000	$0	$1,285,000	$0
202	BASE RECOVERIES	-$312,935,000	-$157,513,000	-$266,285,000	-$134,032,000
	OTHER SUBTOTAL	**$8,847,711,000**	**$2,935,567,350**	**$9,566,368,000**	**$3,008,495,550**
	GRAND TOTAL	**$24,517,430,000**	**$9,925,386,700**	**$26,592,467,000**	**$10,607,517,000**

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
	DRUG MEDI-CAL
62	NARCOTIC TREATMENT PROGRAM
63	RESIDENTIAL TREATMENT SERVICES
64	OUTPATIENT DRUG FREE TREATMENT SERVICES
65	INTENSIVE OUTPATIENT TREATMENT SERVICES
203	PROVIDER FRAUD IMPACT TO DMC PROGRAM
	MENTAL HEALTH
69	SMHS FOR CHILDREN
70	SMHS FOR ADULTS
	MANAGED CARE
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)
215	REGIONAL MODEL
	OTHER
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

MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
190	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)
202	BASE RECOVERIES

NARCOTIC TREATMENT PROGRAM

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$28,878,000	$24,584,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$28,878,000	$24,584,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$28,878,000	$24,584,000

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% CF and 50% Title XIX federal fund participation (FFP). 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, optional, and express lane 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.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

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, CF will be used to match federal funds. Funding for the services is 50% CF and 50% Title XIX FFP. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

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 FFP.

The express lane enrollment population refers to the Department's approach for providing enrollment to targeted ACA populations. The Department will enroll individuals into Medi-Cal based on Supplemental Nutrition Assistance Program (SNAP), known as CalFresh in California. CalFresh adults are assumed to qualify for ACA 100% federal funding. CalFresh parents will enroll into Medi-Cal based on children's income eligibility and are assumed to qualify for Title XIX 50/50% FFP. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% FFP, while the rest qualify for Title XIX 50% FFP.

For the May 2014 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 to project average annual 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:

- The new caseload methodology reduced the caseload projections for the current population.
- The express lane enrollment projections have been added for both current and budget year.
- The Department revised the ACA caseload projections based on updated enrollment data.

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, optional, and express lane populations expected to access this service in January 2014.

5. Assume the caseload projection for the mandatory expansion population is 199 for FY 2013-14 and 1,029 for FY 2014-15.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

6. Assume the caseload projection for the optional expansion population is 1,648 for FY 2013-14 and 5,795 for FY 2014-15.

7. Assume the caseload projection of the express lane population is 275 for FY 2013-14 and 953 for FY 2014-15.

8. The Units of Service (UOS) is based on the most recent complete data, July 2012-June 2013 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 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.

Narcotic Treatment	FY 2009-10 UOS Rate	CIP Deflator	FY 2013-14 Rates*	FY 2013-14 Developed Rates	FY 2013-14 Required Rates
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.

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

FY 2013-14

Current Population				
Regular				
Dosing	22,475	76.9	$11.49	$19,858,000
Individual	22,475	36.0	$14.46	$11,700,000
Group	22,475	0.2	$3.27	$15,000
Total				$31,573,000
EPSDT				
Dosing	324	56.1	$11.49	$209,000
Individual	324	28.2	$14.46	$132,000
Group	324	0.1	$3.27	$0
Total				$341,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

Minor Consent				
Dosing	4	115.0	$11.49	$5,000
Individual	4	69.4	$14.46	$4,000
Group	4	0	$3.27	$0
Total				$9,000
Perinatal				
Dosing	199	44.6	$12.57	$112,000
Individual	199	15.3	$20.70	$63,000
Group	199	0.8	$6.91	$1,000
Total				$176,000
Mandatory				
Regular				
Dosing	196	76.9	$11.49	$173,000
Individual	196	36.0	$14.46	$102,000
Group	196	0.2	$3.27	$0
Total				$275,000
EPSDT				
Dosing	2	56.1	$11.49	$1,000
Individual	2	28.2	$14.46	$1,000
Group	2	0.1	$3.27	$0
Total				$2,000
Perinatal				
Dosing	1	44.6	$12.57	$1,000
Individual	1	15.3	$20.70	$0
Group	1	0.8	$6.91	$0
Total				$1,000
Optional				
Regular				
Dosing	1,625	76.9	$11.49	$1,436,000
Individual	1,625	36	$14.46	$846,000
Group	1,625	0.2	$3.27	$1,000
Total				$2,283,000
EPSDT				
Dosing	16	56.1	$11.49	$10,000
Individual	16	28.2	$14.46	$7,000
Group	16	0.1	$3.27	$0
Total				$17,000
Perinatal				
Dosing	7	44.6	$12.57	$4,000
Individual	7	15.3	$20.70	$2,000
Group	7	0.8	$6.91	$0
Total				$6,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

Express Lane				
Regular				
Dosing	239	76.9	$11.49	$211,000
Individual	239	36	$14.46	$124,000
Group	239	0.2	$3.27	$0
Total				$335,000
Perinatal				
Dosing	36	44.6	$12.57	$20,000
Individual	36	15.3	$20.70	$11,000
Group	36	0.8	$6.91	$0
Total				$31,000
			TOTAL	$35,049,000

FY 2014-15

	Caseload	UOS	Rates	Total
Current Population				
Regular				
Dosing	23,130	76.9	$11.49	$20,437,000
Individual	23,130	36	$14.46	$12,041,000
Group	23,130	0.2	$3.27	$15,000
Total				$32,493,000
EPSDT				
Dosing	329	56.1	$11.49	$212,000
Individual	329	28.2	$14.46	$134,000
Group	329	0.1	$3.27	$0
Total				$346,000
Perinatal				
Dosing	218	44.6	$12.57	$122,000
Individual	218	15.3	$20.70	$69,000
Group	218	0.8	$6.91	$1,000
Total				$192,000
Mandatory				
Regular				
Dosing	1,015	76.9	$11.49	$897,000
Individual	1,015	36	$14.46	$528,000
Group	1,015	0.2	$3.27	$1,000
Total				$1,426,000
EPSDT				
Dosing	10	56.1	$11.49	$6,000
Individual	10	28.2	$14.46	$4,000
Group	10	0.1	$3.27	$0
Total				$2,000
Perinatal				
Dosing	4	44.6	$12.57	$2,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

Individual	4	15.3	$20.70	$1,000
Group	4	0.8	$6.91	$0
Total				$3,000
Optional				
Regular				
Dosing	5,717	76.9	$11.49	$5,051,000
Individual	5,717	36	$14.46	$2,976,000
Group	5,717	0.2	$3.27	$4,000
Total				$8,031,000
EPSDT				
Dosing	55	56.1	$11.49	$35,000
Individual	55	28.2	$14.46	$22,000
Group	55	0.1	$3.27	$0
Total				$57,000
Perinatal				
Dosing	23	44.6	$12.57	$13,000
Individual	23	15.3	$20.70	$7,000
Group	23	0.8	$6.91	$0
Total				$20,000
Express Lane				
Regular				
Dosing	791	76.9	$11.49	$699,000
Individual	791	36	$14.46	$412,000
Group	791	0.2	$3.27	$1,000
Total				$1,112,000
Perinatal				
Dosing	162	44.6	$12.57	$91,000
Individual	162	15.3	$20.70	$51,000
Group	162	0.8	$6.91	$1,000
Total				$143,000
			TOTAL	$43,833,000

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.

Fiscal Year	**Accrual**	**FY 2013-14**	**FY 2014-15**
Regular	$116,850,000	$29,213,000	
Minor Consent	$82,000	$20,000	
Perinatal	$395,000	$99,000	
FY 2012-13	$117,327,000	$29,332,000	$0
Current			
Regular	$31,914,000	$23,935,500	$7,978,500
Minor Consent	$9,000	$6,750	$2,250

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

Perinatal	$176,000	$132,000	$44,000
Mandatory			
Regular	$277,000	$207,750	$69,250
Perinatal	$1,000	$750	$250
Optional			
Regular	$2,300,000	$1,725,000	$575,000
Perinatal	$6,000	$4,500	$1,500
Express Lane			
Regular	$335,000	$251,250	$83,750
Perinatal	$31,000	$23,250	$7,750
FY 2013-14	$35,049,000	$26,286,750	$8,762,250
Current			
Regular	$32,839,000	$0	$24,629,250
Perinatal	$192,000	$0	$144,000
Mandatory			
Regular	$1,436,000	$0	$1,077,000
Perinatal	$3,000	$0	$2,250
Optional			
Regular	$8,088,000	$0	$6,066,000
Perinatal	$20,000	$0	$15,000
Express Lane			
Regular	$1,112,000	$0	$834,000
Perinatal	$143,000	$0	$107,250
FY 2014-15	$43,833,000	$0	$32,874,750
TOTAL		$55,618,750	$41,637,000

12. Funding is 50% CF and 50% Federal Financial 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. Beneficiaries in the Express Lane category are funded by both 100% FFP and 50% CF and 50% FFP for CalFresh adults. A portion of CalFresh children are funded 65% FFP and 35% CF, the remaining children population at 50% CF and 50% FFP.

FY 2013-14	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Current					
Regular (Title XIX)	$52,744,571	$26,372,286	$0	$26,372,286	$0
Regular (Title XXI)	$403,929	$0	$262,554	$141,375	$0
Minor Consent	$26,750	$0	$0	$26,750	$0
Perinatal (Title XXI)	$226,137	$0	$146,989	$79,148	$0
Perinatal (Title XIX)	$4,863	$3,161	$0	$1,702	$0

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 62

Mandatory					
Regular (Title XIX)	$206,171	$103,086	$0	$103,086	$0
Regular (Title XXI)	$1,579	$0	$1,026	$553	$0
Perinatal (Title XXI)	$734	$0	$477	$257	$0
Perinatal (Title XIX)	$16	$10	$0	$6	$0
Optional					
Regular (Title XIX)	$1,725,000	$1,725,000	$0	$0	$0
Perinatal (Title XIX)	$4,500	$4,500	$0	$0	$0
Express Lane					
Regular (Title XIX)	$242,194	$242,194	$0	$0	$0
Regular (Title XIX)	$9,056	$4,528	$0	$4,528	$0
Perinatal (Title XXI)	$6,975	$0	$4,534	$2,441	$0
Perinatal (Title XIX)	$16,275	$8,138	$0	$8,138	$0
Total FY 2013-14	$55,618,750	**$28,462,902**	**$415,580**	$26,740,268	**$0**

FY 2014-15	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Current					
Regular (Title XIX)	$32,359,931	$16,179,966	$0	$16,179,966	$0
Regular (Title XXI)	$247,819	$0	$161,082	$86,737	$0
Minor Consent	$2,250	$0	$0	$2,250	$0
Perinatal (Title XXI)	$184,043	$0	$119,628	$64,415	$0
Perinatal (Title XIX)	$3,957	$2,572	$0	$1,385	$0
Mandatory					
Regular (Title XIX)	$1,137,539	$568,769	$0	$568,769	$0
Regular (Title XXI)	$8,712	$0	$5,662	$3,049	$0
Perinatal (Title XXI)	$2,447	$0	$1,591	$857	$0
Perinatal (Title XIX)	$53	$34	$0	$18	$0
Optional					
Regular (Title XIX)	$6,641,000	$6,641,000	$0	$0	$0
Perinatal (Title XIX)	$16,500	$16,500	$0	$0	$0
Express Lane					
Regular (Title XIX)	$731,677	$731,677	$0	$0	$0
Regular (Title XIX)	$186,073	$93,037	$0	$93,037	$0
Perinatal (Title XXI)	$34,500	$0	$22,425	$12,075	$0
Perinatal (Title XIX)	$80,500	$40,250	$0	$40,250	$0
Total FY 2014-15	$41,637,000	**$24,273,805**	**$310,388**	$17,052,807	**$0**

Funding:

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

RESIDENTIAL TREATMENT SERVICES

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$875,000	$111,421,000
- STATE FUNDS	$0	$36,914,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$875,000	$111,421,000
STATE FUNDS	$0	$36,914,000
FEDERAL FUNDS	$875,000	$74,507,000

DESCRIPTION

Purpose:
This policy change estimates the reimbursement for the Drug Medi-Cal (DMC) Residential Treatment services, previously titled Perinatal Residential Substance Use Disorder Services.

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.

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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% CF and 50% Title XIX Federal Fund Participation (FFP). 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, optional, and express lane expansion population to result in a significant number of new Medi-Cal beneficiaries to receive Residential Treatment services beginning July 2014. 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 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 July 1, 2014. Funding for the services is 50% GF and 50% Title XIX FFP.

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 July 1, 2014. For this population's services, GF will be used to match federal funds. Funding for the services is 50% GF and 50% Title XIX FFP. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

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 July 1, 2014. Funding for the services is 100% Title XIX FFP.

The express lane enrollment population refers to the Department's approach for providing enrollment to targeted ACA populations. The Department will enroll individuals into Medi-Cal based on Supplemental Nutrition Assistance Program (SNAP), known as CalFresh in California. CalFresh adults are assumed to qualify for ACA 100% federal funding. CalFresh parents will enroll into Medi-Cal based on children's income eligibility and are assumed to qualify for Title XIX 50/50% FFP. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% FFP, while the rest qualify for Title XIX 50% FFP.

For the May 2014 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 to project average annual caseload. Presently, the program uses actual DMC billing data to determine unique client caseload to project average annual 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 July 2014, the Residential Treatment Service will be expanded to newly eligible Medi-Cal beneficiaries as a result of the ACA expansion.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 63

- The new caseload methodology reduced the caseload for the current Residential Treatment Service population.
- Express lane enrollment projections have been added for current and budget year caseload.
- The Department revised the ACA caseload projections based on updated enrollment data.

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 Residential Treatment services beginning July 2014. Additional caseload data was developed for the expanded, mandatory, optional, and express lane populations expected to access this service.

5. Assume the caseload projection for the expanded population will be 19,810 for FY 2014-15.

6. Assume the caseload projection for the mandatory expansion population will be 1,645 for FY 2014-15.

7. Assume the caseload projection for the optional expansion population will be 9,264 for FY 2014-15.

8. Assume the caseload projection for the express lane expansion population will be 1,524 for FY 2014-15.

9. The Units of Service (UOS) is based on the most recent complete data, July 2012-June 2013 to calculate an average UOS for existing caseload.

10. 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.

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

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

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 63

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

FY 2013-14	Caseload	UOS	Rates	Total
Current				
DMC Perinatal	277	46.9	$97.72	$1,270,000

FY 2014-15	Caseload	UOS	Rates	Total
Current				
DMC Perinatal	264	46.9	$97.72	$1,210,000
Expanded Population				
DMC Regular	18,612	46.9	$97.72	$85,300,000
Minor Consent	55	46.9	$97.72	$252,000
DMC Perinatal	1,143	46.9	$97.72	$5,238,000
Total	19,810			$90,790,000
Mandatory Population				
DMC Regular	1,546	46.9	$97.72	$7,085,000
Minor Consent	4	46.9	$97.72	$18,000
DMC Perinatal	95	46.9	$97.72	$435,000
Total	1,645			$7,538,000
Optional Population				
DMC Regular	8,727	46.9	$97.72	$39,996,000
Minor Consent	-	46.9	$97.72	$0
DMC Perinatal	537	46.9	$97.72	$2,461,000
Total	9,264			$42,457,000
Express Lane				
DMC Regular	1,265	46.9	$97.72	$5,798,000
Minor Consent	-	46.9	$97.72	$0
DMC Perinatal	259	46.9	$97.72	$1,187,000
Total	1,524			$6,985,000
				$148,980,000

12. 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
Perinatal	$1,578,000	$394,000	
FY 2012-13	$1,578,000	$394,000	$0
Current			
Perinatal	$1,270,000	$952,500	$317,500
FY 2013-14	$1,270,000	$952,500	$317,500

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BASE POLICY CHANGE NUMBER: 63

Current			
Perinatal	$1,210,000	$0	$907,500
Expansion			
Regular	$85,300,000	$0	$63,975,000
Minor Consent	$252,000	$0	$189,000
Perinatal	$5,238,000	$0	$3,928,500
Mandatory			
Regular	$7,085,000	$0	$5,313,750
Minor Consent	$18,000	$0	$13,500
Perinatal	$435,000	$0	$326,250
Optional			
Regular	$39,996,000	$0	$29,997,000
Minor Consent	$0	$0	$0
Perinatal	$2,461,000	$0	$1,845,750
Express Lane			
Regular	$5,798,000	$0	$4,348,500
Minor Consent	$0	$0	$0
Perinatal	$1,187,000	$0	$890,250
FY 2014-15	$148,980,000	$0	$111,735,000
		$1,346,500	$112,052,500

13. Funding is 50% CF and 50% 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. Beneficiaries in the Express Lane category are funded by both 100% FFP and 50% GF and 50% FFP for CalFresh adults. A portion of CalFresh children are funded 65% FFP and 35% GF and the remaining children population at 50% GF and 50% FFP.

FY 2013-14	TF	FFP Title XIX	FFP Title XXI	CF	GF
Current					
Perinatal (Title XXI)	$1,318,156	$0	$856,802	$461,355	$0
Perinatal (Title XIX)	$28,344	$18,423	$0	$9,920	$0
Total FY 2013-14	$1,346,500	**$18,423**	**$856,802**	$471,275	**$0**

FY 2014-15	TF	FFP Title XIX	FFP Title XXI	CF	GF
Current					
Perinatal (Title XXI)	$1,199,214	$0	$779,489	$419,725	$0
Perinatal (Title XIX)	$25,786	$16,761	$0	$9,025	$0
Expanded					
Regular (Title XIX)	$63,488,790	$31,744,395	$0	$0	$31,744,395
Regular (Title XXI)	$486,210	$0	$316,037	$0	$170,174
Minor Consent	$189,000	$0	$0	$189,000	$0
Perinatal (Title XXI)	$3,845,805	$0	$2,499,773	$0	$1,346,032
Perinatal (Title XIX)	$82,695	$41,347	$0	$0	$41,347
Mandatory					
Regular (Title XIX)	$5,273,366	$2,636,683	$0	$0	$2,636,683

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 63

Regular (Title XXI)	$40,385	$0	$26,250	$0	$14,135
Minor Consent	$13,500	$0	$0	$13,500	$0
Perinatal (Title XXI)	$319,382	$0	$207,599	$0	$111,784
Perinatal (Title XIX)	$6,868	$3,434	$0	$0	$3,434
Optional					
Regular (Title XIX)	$29,997,000	$29,997,000	$0	$0	$0
Perinatal (Title XIX)	$1,845,750	$1,845,750	$0	$0	$0
Express Lane					
Regular (Title XIX)	$3,466,845	$3,466,845	$0	$0	$0
Regular (Title XIX)	$881,655	$440,827	$0	$0	$440,827
Perinatal (Title XXI)	$267,075	$0	$173,599	$0	$93,476
Perinatal (Title XIX)	$623,175	$311,588	$0	$0	$311,588
Total FY 2014-15	$112,052,500	**$70,504,630**	**$4,002,746**	$631,250	**$36,913,874**

Funding:

50%Title XIX / 50% GF (4260-101-0001/0890)
65% Title XXI / 35% GF (4260-113-0001/0890)
100% Title XIX (4260-101-0890)
100% Title XXI (4260-113-0890)

OUTPATIENT DRUG FREE TREATMENT SERVICES

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$18,915,000	$26,379,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,915,000	$26,379,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$18,915,000	$26,379,000

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% CF and 50% Title XIX Federal Fund Participation (FFP). Certain aid codes are eligible for Title XXI federal reimbursement at

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

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, optional, and express lane 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, CF will be used to match federal funds. Funding for the services is 50% CF and 50% Title XIX FFP. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

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 FFP.

The express lane enrollment population refers to the Department's approach for providing enrollment to targeted ACA populations. The Department will enroll individuals into Medi-Cal based on Supplemental Nutrition Assistance Program (SNAP), known as CalFresh in California. CalFresh adults are assumed to qualify for ACA 100% federal funding. CalFresh parents will enroll into Medi-Cal based on children's income eligibility and are assumed to qualify for Title XIX 50/50% FFP. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% FFP, while the rest qualify for Title XIX 50% FFP.

For the May 2014 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 to project average annual caseload. Presently, the program uses actual DMC billing data to determine unique client caseload to project average annual 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:

- The new caseload methodology reduced the caseload projections for the current ODF population.
- Express lane caseload was added for current and budget year.
- The Department revised the ACA caseload projections based on enrollment data.

Methodology:

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent (MC), and Perinatal.

2. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.

OUTPATIENT DRUG FREE TREATMENT SERVICES

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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, optional, and the express lane populations expected to access this service in January 2014.

5. Assume the caseload projection for the mandatory expansion population is 481 for FY 2013-14 and 2,484 for FY 2014-15.

6. Assume the caseload projection for the optional expansion population is 3,978 for FY 2013-14 and 13,990 for FY 2014-15.

7. Assume the caseload projection for the express lane population is 664 for FY 2013-14 and 2,301 for FY 2014-15.

8. The Units of Service (UOS) data is based on the most recent complete data, July 2012-June 2013, 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 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.

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

FY 2013-14	Caseload	UOS	Rates	Total
Current Population				
Regular				
Individual	19,571	2.6	$72.32	$3,680,000
Group	19,571	27.6	$29.39	$15,875,000
Total				$19,555,000

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EPSDT				
Individual	7,814	2.8	$72.32	$1,582,000
Group	7,814	17.4	$29.39	$3,996,000
Total				$5,578,000
Minor Consent				
Individual	9,830	3.3	$72.32	$2,346,000
Group	9,830	28.9	$29.39	$8,349,000
Total				$10,695,000
Perinatal				
Individual	576	1.5	$103.52	$89,000
Group	576	12.1	$62.24	$434,000
Total				$523,000
Total Current	37,791			$36,351,000
Mandatory				
Regular				
Individual	260	2.6	$72.32	$49,000
Group	260	27.6	$29.39	$211,000
Total				$260,000
EPSDT				
Individual	90	2.8	$72.32	$18,000
Group	90	17.4	$29.39	$46,000
Total				$64,000
Minor Consent				
Individual	127	3.3	$72.32	$30,000
Group	127	28.9	$29.39	$108,000
Total				$138,000
Perinatal				
Individual	4	1.5	$103.52	$1,000
Group	4	12.1	$62.24	$3,000
Total				$4,000
Total Mandatory	481			$466,000
Optional				
Regular				
Individual	3,200	2.6	$72.32	$602,000
Group	3,200	27.6	$29.39	$2,596,000
Total				$3,198,000
EPSDT				
Individual	746	2.8	$72.32	$151,000
Group	746	17.4	$29.39	$381,000
Total				$532,000
Perinatal				
Individual	32	1.5	$103.52	$5,000
Group	32	12.1	$62.24	$24,000
Total				$29,000

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Total Optional	3,978			$3,759,000
Express Lane				
Regular				
Individual	578	2.6	$72.32	$109,000
Group	578	27.6	$29.39	$469,000
Total				$578,000
Perinatal				
Individual	86	1.5	$103.52	$13,000
Group	86	12.1	$62.24	$65,000
Total				$78,000
Total Express Lane	664			$656,000
			TOTAL	$41,232,000

FY 2014-15	Caseload	UOS	Rates	Total
Current Population				
Regular				
Individual	20,183	2.6	$72.32	$3,795,000
Group	20,183	27.6	$29.39	$16,372,000
				$20,167,000
EPSDT				
Individual	8,201	2.8	$72.32	$1,661,000
Group	8,201	17.4	$29.39	$4,194,000
				$5,855,000
Minor Consent				
Individual	10,058	3.3	$72.32	$2,400,000
Group	10,058	28.9	$29.39	$8,543,000
				$10,943,000
Perinatal				
Individual	576	1.5	$103.52	$89,000
Group	576	12.1	$62.24	$434,000
				$523,000
Total Current	39,018			$37,488,000
Mandatory				
Regular				
Individual	1,341	2.6	$72.32	$252,000
Group	1,341	27.6	$29.39	$1,088,000
				$1,340,000
EPSDT				
Individual	461	2.8	$72.32	$93,000
Group	461	17.4	$29.39	$236,000
				$329,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

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Minor Consent				
Individual	660	3.3	$72.32	$158,000
Group	660	28.9	$29.39	$561,000
				$719,000
Perinatal				
Individual	22	1.5	$103.52	$3,000
Group	22	12.1	$62.24	$17,000
				$20,000
Total Mandatory	2,484			$2,408,000
Optional				
Regular				
Individual	11,274	2.6	$72.32	$2,120,000
Group	11,274	27.6	$29.39	$9,145,000
				$11,265,000
EPSDT				
Individual	2,598	2.8	$72.32	$526,000
Group	2,598	17.4	$29.39	$1,329,000
				$1,855,000
Perinatal				
Individual	118	1.5	$103.52	$18,000
Group	118	12.1	$62.24	$89,000
				$107,000
Total Optional	13,990			$13,227,000
Express Lane				
Regular				
Individual	1,910	2.6	$72.32	$359,000
Group	1,910	27.6	$29.39	$1,549,000
Total				$1,908,000
Perinatal				
Individual	391	1.5	$103.52	$61,000
Group	391	12.1	$62.24	$294,000
Total				$355,000
Total Express Lane	2,301			$2,263,000
Total				$55,386,000

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.

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
FY 2012-13	$63,513,000	$15,878,000	$0

Current

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

Regular	$25,133,000	$18,849,750	$6,283,250
Minor Consent	$10,695,000	$8,021,250	$2,673,750
Perinatal	$523,000	$392,250	$130,750
Mandatory			
Regular	$324,000	$243,000	$81,000
Minor Consent	$138,000	$103,500	$34,500
Perinatal	$4,000	$3,000	$1,000
Optional			
Regular	$3,730,000	$2,797,500	$932,500
Minor Consent	$0	$0	$0
Perinatal	$29,000	$21,750	$7,250
Express Lane			
Regular	$578,000	$433,500	$144,500
Perinatal	$78,000	$58,500	$19,500
FY 2013-14	$41,232,000	$30,924,000	$10,308,000
Current			
Regular	$26,022,000	$0	$19,516,500
Minor Consent	$10,943,000	$0	$8,207,250
Perinatal	$523,000	$0	$392,250
Mandatory			
Regular	$1,669,000	$0	$1,251,750
Minor Consent	$719,000	$0	$539,250
Perinatal	$20,000	$0	$15,000
Optional			
Regular	$13,120,000	$0	$9,840,000
Minor Consent	$0	$0	$0
Perinatal	$107,000	$0	$80,250
Express Lane			
Regular	$1,908,000	$0	$1,431,000
Perinatal	$355,000	$0	$266,250
FY 2014-15	$55,386,000	$0	$41,539,500
		$46,802,000	$51,847,500

12. Funding is 50% CF and 50% FFP. Minor consent (MC) 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. Beneficiaries in the Express Lane category are funded by both 100% FFP and 50% CF and 50% FFP for CalFresh adults. A portion of CalFresh children are funded 65% FFP and 35% CF and the remaining children population at 50% CF and 50% FFP.

FY 2013-14	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Current					
Regular (Title XIX)	$30,083,366	$15,041,683	$0	$15,041,683	$0

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

Regular (Title XXI)	$230,385	$0	$149,750	$80,635	$0
Minor Consent	$12,330,250	$0	$0	$12,330,250	$0
Perinatal (Title XXI)	$486,783	$0	$316,409	$170,374	$0
Perinatal (Title XIX)	$10,467	$6,804	$0	$3,663	$0
Mandatory					
Regular (Title XIX)	$241,153	$120,577	$0	$120,577	$0
Regular (Title XXI)	$1,847	$0	$1,200	$646	$0
Minor Consent	$103,500	$0	$0	$103,500	$0
Perinatal (Title XXI)	$2,937	$0	$1,909	$1,028	$0
Perinatal (Title XIX)	$63	$41	$0	$22	$0
Optional					
Regular (Title XIX)	$2,776,239	$2,776,239	$0	$0	$0
Regular (Title XIX)	$21,261	$21,261	$0	$0	$0
Minor Consent	$0	$0	$0	$0	$0
Perinatal (Title XIX)	$21,292	$21,292	$0	$0	$0
Perinatal (Title XIX)	$458	$458	$0	$0	$0
Express Lane					
Regular (Title XIX)	$417,875	$417,875	$0	$0	$0
Regular (Title XIX)	$15,625	$7,812	$0	$7,812	$0
Perinatal (Title XXI)	$17,550	$0	$11,408	$6,143	$0
Perinatal (Title XIX)	$40,950	$20,475	$0	$20,475	$0
Total FY 2013-14	$46,802,000	**$18,434,517**	**$480,676**	$27,886,808	**$0**

FY 2014-15	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Current					
Regular (Title XIX)	$25,603,672	$12,801,836	$0	$12,801,836	$0
Regular (Title XXI)	$196,078	$0	$127,451	$68,627	$0
Minor Consent	$10,881,000	$0	$0	$10,881,000	$0
Perinatal (Title XXI)	$511,991	$0	$332,794	$179,197	$0
Perinatal (Title XIX)	$11,009	$7,156	$0	$3,853	$0
Mandatory					
Regular (Title XIX)	$1,322,621	$661,311	$0	$661,311	$0
Regular (Title XXI)	$10,129	$0	$6,584	$3,545	$0
Minor Consent	$573,750	$0	$0	$573,750	$0
Perinatal (Title XXI)	$15,663	$0	$10,181	$5,482	$0
Perinatal (Title XIX)	$337	$219	$0	$118	$0
Optional					
Regular (Title XIX)	$10,690,629	$10,690,629	$0	$0	$0
Regular (Title XIX)	$81,871	$81,871	$0	$0	$0
Minor Consent	$0	$0	$0	$0	$0
Perinatal (Title XIX)	$85,811	$85,811	$0	$0	$0
Perinatal (Title XIX)	$1,689	$1,689	$0	$0	$0
Express Lane					
Regular (Title XIX)	$1,256,069	$1,256,069	$0	$0	$0
Regular (Title XIX)	$319,431	$159,716	$0	$159,716	$0
Perinatal (Title XXI)	$85,725	$0	$55,721	$30,004	$0
Perinatal (Title XIX)	$200,025	$100,013	$0	$100,013	$0
Total FY 2014-15	$ 51,847,500	**$25,846,318**	**$532,731**	$ 25,468,451	**$ -**

Funding:
100%Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)

INTENSIVE OUTPATIENT TREATMENT SERVICES

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$29,190,000	$66,590,000
- STATE FUNDS	$8,184,000	$20,321,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$29,190,000	$66,590,000
STATE FUNDS	$8,184,000	$20,321,000
FEDERAL FUNDS	$21,006,000	$46,269,000

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% CF and 50% Title XIX Federal Fund Participation (FFP). 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 TREATMENT 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, optional and express lane 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% General Funds (GF) and 50% Title XIX FFP.

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, GF will be used to match federal funds. Funding for the services is 50% GF and 50% Title XIX FFP. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

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 FFP.

The express lane enrollment population refers to the Department's approach for providing enrollment to targeted ACA populations. The Department will enroll individuals into Medi-Cal based on Supplemental Nutrition Assistance Program (SNAP), known as CalFresh in California. CalFresh adults are assumed to qualify for ACA 100% FFP. CalFresh parents will enroll into Medi-Cal based on children's income eligibility and are assumed to qualify for Title XIX 50/50% FFP. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% FFP, while the rest qualify for Title XIX 50% FFP.

For the May 2014 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 to project average annual caseload. Presently, the program uses actual DMC billing data to determine unique client caseload to project average annual 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:

- The new caseload methodology reduced the caseload projections for the current IOT population.
- Express lane caseload was added for the current and budget year.
- The Department revised the ACA caseload projections based on enrollment data.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

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 DMC beginning January 2014. Additional caseload data for the expanded eligibles was developed for expanded, mandatory, optional, and express lane 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 383 for FY 2013-14 and 1,984 for FY 2014-15.

7. Assume optional expansion population is 3,178 for FY 2013-14 and 11,176 for FY 2014-15.

8. Assume express lane expansion population is 530 for FY 2013-14 and 1,838 for FY 2014-15.

9. The Units of Service (UOS) is based on the most recent complete data, July 2012-June 2013 to calculate an average UOS.

10. 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.

IOT	FY 2009-10 UOS Rate	CIP Deflator	FY 2013-14 Rates *	FY 2013-14 Developed Rates	FY 2013-14 Required Rates
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.

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

FY 2013-14	Caseload	UOS	Rates	Total
Current				
Regular & EPSDT	6,827	29.1	$62.15	$12,347,000
Perinatal	410	20.7	$79.39	$674,000
Total	7,237			$13,021,000
Expanded				

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

Regular & EPSDT	11,208	29.1	$62.15	$20,270,000
Minor Consent	33	20.7	$62.15	$42,000
Perinatal	688	20.7	$79.39	$1,131,000
Total	11,929			$21,443,000
Mandatory				
Regular & EPSDT	360	29.1	$62.15	$651,000
Minor Consent	1	20.7	$62.15	$1,000
Perinatal	22	20.7	$79.39	$36,000
Total	383			$688,000
Optional				
Regular & EPSDT	2,989	29.1	$62.15	$5,406,000
Minor Consent	-	20.7	$62.15	$0
Perinatal	189	20.7	$79.39	$311,000
Total	3,178			$5,717,000
Express Lane				
Regular & EPSDT	461	29.1	$62.15	$834,000
Minor Consent	-	20.7	$62.15	$0
Perinatal	69	20.7	$79.39	$113,000
Total	530			$947,000
Total				$41,816,000

FY 2014-15	Caseload	UOS	Rates	Total
Current				
Regular & EPSDT	7,351	29.1	$62.15	$13,295,000
Perinatal	410	20.7	$79.39	$674,000
Total	7,761			$13,969,000
Expanded				
Regular & EPSDT	22,416	29.1	$62.15	$40,541,000
Minor Consent	66	20.7	$62.15	$85,000
Perinatal	1,376	20.7	$79.39	$2,261,000
Total	23,858			$42,887,000
Mandatory				
Regular & EPSDT	1,865	29.1	$62.15	$3,373,000
Minor Consent	6	20.7	$62.15	$8,000
Perinatal	113	20.7	$79.39	$186,000
Total	1,984			$3,567,000
Optional				
Regular & EPSDT	10,501	29.1	$62.15	$18,992,000
Minor Consent	-	20.7	$62.15	$0
Perinatal	675	20.7	$79.39	$1,109,000
Total	11,176			$20,101,000
Express Lane				

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

Regular & EPSDT	1,526	29.1	$62.15	$2,760,000
Minor Consent	-	20.7	$62.15	$0
Perinatal	312	20.7	$79.39	$513,000
Total	1,838			$3,273,000
Total				$83,797,000

12. 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	$20,204,000	$5,051,000	$0
Perinatal	$770,000	$193,000	$0
FY 2012-13	$20,974,000	$5,244,000	$0
Current			
Regular	$12,347,000	$9,260,250	$3,086,750
Perinatal	$674,000	$505,500	$168,500
Expanded			
Regular	$20,270,000	$15,202,500	$5,067,500
Minor Consent	$42,000	$31,500	$10,500
Perinatal	$1,131,000	$848,250	$282,750
Mandatory			
Regular	$651,000	$488,250	$162,750
Minor Consent	$1,000	$750	$250
Perinatal	$36,000	$27,000	$9,000
Optional			
Regular	$5,406,000	$4,054,500	$1,351,500
Perinatal	$311,000	$233,250	$77,750
Express Lane			
Regular & EPSDT	$834,000	$625,500	$208,500
Perinatal	$113,000	$84,750	$28,250
FY 2013-14	$41,816,000	$31,362,000	$10,454,000
Current			
Regular	$13,295,000	$0	$9,971,250
Perinatal	$674,000	$0	$505,500
Expanded			
Regular	$40,541,000	$0	$30,405,750
Minor Consent	$85,000	$0	$63,750
Perinatal	$2,261,000	$0	$1,695,750
Mandatory			

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

Regular	$3,373,000	$0	$2,529,750
Minor Consent	$8,000	$0	$6,000
Perinatal	$186,000	$0	$139,500
Optional			
Regular	$18,992,000	$0	$14,244,000
Perinatal	$1,109,000	$0	$831,750
Express Lane			
Regular & EPSDT	$2,760,000	$0	$2,070,000
Perinatal	$513,000	$0	$384,750
FY 2014-15	$83,797,000	$0	$62,847,750
		$36,606,000	$73,301,750

13. Funding is 50% CF and 50% 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. Beneficiaries in the Express Lane category are funded by both 100% FFP and 50% GF and 50% FFP for CalFresh adults. A portion of CalFresh children are funded 65% FFP and 35% GF and the remaining children population at 50% GF and 50% FFP.

FY 2013-14	TF	FFP Title XIX	FFP Title XXI	CF	GF
Current					
Regular (Title XIX)	$14,202,485	$7,101,242	$0	$7,101,242	$0
Regular (Title XXI)	$108,766	$0	$70,698	$38,068	$0
Perinatal (Title XXI)	$683,797	$0	$444,468	$239,329	$0
Perinatal (Title XIX)	$14,703	$9,557	$0	$5,146	$0
Expanded					
Regular (Title XIX)	$15,086,961	$7,543,481	$0	$0	$7,543,481
Regular (Title XXI)	$115,539	$0	$75,100	$0	$40,439
Minor Consent	$31,500	$0	$0	$31,500	$0
Perinatal (Title XXI)	$830,394	$0	$539,756	$0	$290,638
Perinatal (Title XIX)	$17,856	$11,606	$0	$0	$6,249
Mandatory					
Regular (Title XIX)	$484,539	$242,270	$0	$0	$242,270
Regular (Title XXI)	$3,711	$0	$2,412	$0	$1,299
Minor Consent	$750	$0	$0	$750	$0
Perinatal (Title XXI)	$26,432	$0	$17,181	$0	$9,251
Perinatal (Title XIX)	$568	$369	$0	$0	$199
Optional					
Regular (Title XIX)	$4,023,686	$4,023,686	$0	$0	$0
Regular (Title XIX)	$30,814	$30,814	$0	$0	$0
Perinatal (Title XXI)	$228,340	$228,340	$0	$0	$0
Perinatal (Title XIX)	$4,910	$4,910	$0	$0	$0
Express Lane					
Regular (Title XIX)	$602,955	$602,955	$0	$0	$0
Regular (Title XIX)	$22,545	$11,273	$0	$0	$11,273
Perinatal (Title XXI)	$25,425	$0	$16,526	$0	$8,899
Perinatal (Title XIX)	$59,325	$29,663	$0	$0	$29,663
Total FY 2013-14	$36,606,000	**$19,840,165**	**$1,166,141**	$7,416,035	**$8,183,659**

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

FY 2014-15	TF	FFP Title XIX	FFP Title XXI	CF	GF
Current					
Regular (Title XIX)	$12,958,759	$6,479,380	$0	$6,479,380	$0
Regular (Title XXI)	$99,241	$0	$64,507	$34,734	$0
Perinatal (Title XXI)	$659,812	$0	$428,878	$230,934	$0
Perinatal (Title XXI)	$14,188	$9,222	$0	$4,966	$0
Expanded					
Regular (Title XIX)	$35,203,653	$17,601,827	$0	$0	$17,601,827
Regular (Title XXI)	$269,597	$0	$175,238	$0	$94,359
Minor Consent	$74,250	$0	$0	$74,250	$0
Perinatal (Title XXI)	$1,936,853	$0	$1,258,954	$0	$677,898
Perinatal (Title XIX)	$41,647	$27,071	$0	$0	$14,577
Mandatory					
Regular (Title XIX)	$2,672,037	$1,336,019	$0	$0	$1,336,019
Regular (Title XXI)	$20,463	$0	$13,301	$0	$7,162
Minor Consent	$6,250	$0	$0	$6,250	$0
Perinatal (Title XXI)	$145,374	$0	$94,493	$0	$50,881
Perinatal (Title XIX)	$3,126	$2,032	$0	$0	$1,094
Optional					
Regular (Title XIX)	$15,476,974	$15,476,974	$0	$0	$0
Regular (Title XIX)	$118,526	$118,526	$0	$0	$118,526
Perinatal (Title XIX)	$891,992	$891,992	$0	$0	$0
Perinatal (Title XIX)	$17,508	$17,508	$0	$0	$0
Express Lane					
Regular (Title XIX)	$1,816,536	$1,816,536	$0	$0	$0
Regular (Title XIX)	$461,964	$230,982	$0	$0	$230,982
Perinatal (Title XXI)	$123,900	$0	$80,535	$0	$43,365
Perinatal (Title XIX)	$289,100	$144,550	$0	$0	$144,550
Total FY 2014-15	$73,301,750	**$44,152,617**	**$2,115,906**	$6,830,514	**$20,321,239**

Funding:

50% Title XIX FFP / 50% GF (4260-101-0001/0890)
65% Title XXI FFP / 35% GF (4260-113-0001/0890)
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)

SMHS FOR CHILDREN

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$827,218,000	$875,642,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$827,218,000	$875,642,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$827,218,000	$875,642,000

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:
SMHS for Children expenditures increased due to the HFP SED transition into Medi-Cal (completed Nov 2013). Changes are due to additional approved claims data.

Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) and 70 months Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2013, with dates of service from July 2007 through September 2013. The FFS data is current as of December 31, 2013, with dates of service from July 2007 through July 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)

	TF	SD/MC	FFS Inpatient
FY 2011-12	$1,355,856	$1,296,827	$59,029
FY 2012-13	$1,566,354	$1,501,567	$64,787
FY 2013-14	$1,655,748	$1,585,700	$70,048
FY 2014-15	$1,747,880	$1,673,284	$74,596

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	$1,355,856	$681,789	$674,067
FY 2012-13	$1,566,354	$792,839	$773,515
FY 2013-14	$1,655,748	$843,560	$812,188
FY 2014-15	$1,747,880	$891,900	$855,980

6. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 33% of FY 2012-13 claims, and 66% 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, 24% of FY 2012-13 claims, and 75% 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	$13,558	$12,968	$590
FY 2012-13	$512,233	$496,630	$15,603
FY 2013-14	$1,097,866	$1,045,388	$52,478
Total FY 2013-14	$1,623,657	$1,554,986	$68,671

7. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 33% of FY 2013-14 claims, and 66% 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, 24% of FY 2013-14 claims, and 75% of FY 2014-15 claims. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2012-13	$15,664	$15,016	$648
FY 2013-14	$541,326	$524,456	$16,870
FY 2014-15	$1,159,013	$1,103,128	$55,885
Total FY 2014-15	$1,716,003	$1,642,600	$73,403

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

(Dollars In Thousands)

Cash Estimate	TF	FFP	M-CHIP*	County
Total FY 2013-14	$1,623,657	**$760,526**	**$66,692**	$796,439
Total FY 2014-15	$1,716,003	**$799,200**	**$76,442**	$840,361

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$549,275,000	$565,334,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$549,275,000	$565,334,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$549,275,000	$565,334,000

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 70 months of Short-Doyle/Medi-Cal (SD/MC) and 70 months of Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2013, with dates of service from July 2007 through September 2013. The FFS data is current as of December 31, 2013, with dates of service from July 2007 through July 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)

	Total	SD/MC	FFS Inpatient
FY 2011-12	$924,299	$793,206	$131,093
FY 2012-13	$1,087,480	$945,099	$142,381
FY 2013-14	$1,105,921	$957,486	$148,435
FY 2014-15	$1,142,787	$987,382	$155,405

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)

	Total	FFP	CF
FY 2011-12	$924,299	$462,150	$462,149
FY 2012-13	$1,087,480	$543,740	$543,740
FY 2013-14	$1,105,921	$552,961	$552,960
FY 2014-15	$1,142,787	$571,394	$571,393

6. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 33% of FY 2012-13 claims, and 66% 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, 24% of FY 2012-13 claims, and 75% of FY 2013-14 claims. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2011-12	$9,243	$7,932	$1,311
FY 2012-13	$346,873	$312,583	$34,290
FY 2013-14	$742,433	$631,231	$111,202
Total FY 2013-14	$1,098,549	$951,746	$146,803

7. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 33% of FY 2013-14 claims, and 66% 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, 24% of FY 2013-14 claims, and 75% of FY 2014-15 claims. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2012-13	$10,875	$9,451	$1,424
FY 2013-14	$352,428	$316,680	$35,748
FY 2014-15	$767,364	$650,940	$116,424
Total FY 2014-15	$1,130,667	$977,071	$153,596

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

(Dollars In Thousands)

Cash Estimate	TF	FFP	County
Total FY 2013-14	$1,098,549	**$549,275**	$549,274
Total FY 2014-15	$1,130,667	**$565,334**	$565,333

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,234,423,000	$8,792,854,000
- STATE FUNDS	$4,035,254,150	$4,309,888,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,234,423,000	$8,792,854,000
STATE FUNDS	$4,035,254,150	$4,309,888,250
FEDERAL FUNDS	$4,199,168,850	$4,482,965,750

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.

Reason for Change from Prior Estimate:
Rates and eligibles were updated, and baseline rates were used. Additionally, the Healthy Families Program (HFP) was transitioned into the Optional Targeted Low Income Children Program (OTLICP), which is accounted for in this policy change.

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. IGT increases are budgeted in PC 118 Managed Care Rate Range IGTs.

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
   - Mental Health Increases
   - Transitioned SPD eligibles
   - Diagnosis Related Groups

4. SB 78 imposed a 3.9375% statewide MCO tax on Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.

5. 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 the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Because these services are budgeted in PC 22 Mental Health Shift and Expansion, an adjustment was made to remove these dollars from this PC.

7. The savings from AB 97 are included in the rates. Because these savings are budgeted in PC 157 10% Provider Payment Reduction, an adjustment was made to restore those dollars in this PC.

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

9. The transition of the HFP into the OTLICP accounts for an additional 5,906,215 member months and $417 million in FY 201314, and 5,997,123 member months and $450 million in FY 201415. FY 2013-14 and 201415 OTLICP is budgeted at a FMAP split of 65/35 in the managed care model policy changes.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 114

(Dollars in Thousands)

FY 2013-14	Eligible Months	Total
Alameda	2,248,080	$502,113
Contra Costa	1,316,390	$267,463
Kern	2,256,246	$346,273
Los Angeles	20,983,927	$3,569,429
Riverside	4,315,290	$653,375
San Bernardino	4,803,341	$750,811
San Francisco	1,004,643	$276,252
San Joaquin	1,826,391	$306,009
Santa Clara	2,311,191	$399,255
Stanislaus	1,240,734	$232,879
Tulare	1,672,298	$256,505
Fresno	3,075,320	$561,178
Kings	350,336	$57,174
Madera	424,549	$64,152
Total FY 2013-14	47,828,736	$8,242,868
AB 97 Adjustment		$47,489
Mental Health Adjustment		-$55,934
Total with Adjustments		**$8,234,423**

FY 2014-15	Eligible Months	Total
Alameda	2,289,658	$566,348
Contra Costa	1,363,910	$310,337
Kern	2,332,210	$380,080
Los Angeles	21,289,083	$3,695,271
Riverside	4,428,277	$767,224
San Bernardino	4,962,228	$852,482
San Francisco	1,022,805	$296,915
San Joaquin	1,895,192	$338,254
Santa Clara	2,346,421	$433,003
Stanislaus	1,340,115	$291,316
Tulare	1,726,991	$275,026
Fresno	3,134,108	$610,339
Kings	355,648	$62,314
Madera	432,856	$72,347
Total FY 2014-15	48,919,502	$8,951,256
AB 97 Adjustment		$64,708
Mental Health Adjustment		-$223,110
Total with Adjustments		**$8,792,854**

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 114

Funding:
(in Thousands)
FY 2013-14:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$7,724,084	$3,862,042	$3,862,042
State GF	4260-101-0001	$19,805	$19,805	$0
Family Planning 90/10 GF	4260-101-0001/0890	$73,119	$7,312	$65,807
Title XXI 65/35 GF	4260-113-0001/0890	$417,415	$146,095	$271,320
Total (rounded)		**$8,234,423**	**$4,035,254**	**$4,199,169**

FY 2014-15:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$8,249,446	$4,124,723	$4,124,723
State GF	4260-101-0001	$20,388	$20,388	$0
Family Planning 90/10 GF	4260-101-0001/0890	$73,119	$7,312	$65,807
Title XXI 65/35 GF	4260-113-0001/0890	$449,901	$157,465	$292,436
Total (rounded)		**$8,792,854**	**$4,309,888**	**$4,482,966**

COUNTY ORGANIZED HEALTH SYSTEMS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,134,702,000	$4,307,708,000
- STATE FUNDS	$2,028,588,050	$2,112,577,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,134,702,000	$4,307,708,000
STATE FUNDS	$2,028,588,050	$2,112,577,900
FEDERAL FUNDS	$2,106,113,950	$2,195,130,100

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 127 Managed Care Expansion to Rural Counties
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.

Reason for Change from Prior Estimate:
Rates and eligibles were updated, and baseline rates were used. Eligibles in the eight rural counties that were previously budgeted for in PC 127 Managed Care Expansion to Rural Counties are now budgeted in the policy change. Additionally, the Healthy Families Program (HFP) was transitioned into the Optional Targeted Low Income Children Program (OTLICP), which is accounted for in this policy change.

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. IGT increases are budgeted in PC 118 Managed Care Rate Range IGTs.

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
    - Mental Health Increase
    - Diagnosis Related Groups

5. SB 78 applied a 3.9375% statewide tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.

6. 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 the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy change.

7. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Because these services are budgeted in PC 22 Mental Health Shift and Expansion, an adjustment was made to remove these dollars from this PC.

8. The savings from AB 97 are included in the rates. Because these savings are budgeted in PC 157 10% Provider Payment Reduction, an adjustment was made to restore those dollars in this PC.

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

10. The transition of the HFP into the OTLICP accounts for an additional 2,481,022 member months and $220 million in FY 2013-14, and 2,584,036 member months and $235 million in FY 2014-15. FY 2013-14 and 2014-15 OTLICP is budgeted at a FMAP split of 65/35 in the managed care model policy changes.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 115

11. In FY 2013-14, the Department will defer one managed care capitation for the eight COHS expansion counties.

(Dollars in Thousands) **FY 2013-14**	**Eligible Months**	**Total**
San Luis Obispo	398,115	$101,241
Santa Barbara	921,454	$233,445
San Mateo	886,278	$356,129
Solano	820,256	$253,535
Santa Cruz	503,296	$133,954
CalOPTIMA(Orange)	5,635,190	$1,326,718
Napa	216,069	$65,081
Monterey	1,150,213	$259,727
Yolo	377,914	$115,229
Sonoma	801,338	$235,766
Merced	993,794	$197,715
Marin	243,273	$108,375
Mendocino	271,397	$76,888
Ventura	1,439,047	$336,190
Del Norte	83,420	$25,406
Humboldt	294,462	$93,351
Lake	193,313	$57,571
Lassen	49,937	$15,772
Modoc	21,335	$9,797
Shasta	435,867	$145,765
Siskiyou	113,582	$32,521
Trinity	28,482	$8,810
Total FY 2013-14	15,878,032	$4,188,986
Mental Health Adjustment		-$27,885
AB 97 Adjustment		$12,500
Deferral for 8 Expansion Counties		-$38,899
Total with Adjustments		**$4,134,702**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 115

(Dollars in Thousands) **FY 2014-15**	**Eligible Months**	**Total**
San Luis Obispo	411,179	$108,733
Santa Barbara	931,638	$246,795
San Mateo	917,677	$351,074
Solano	844,637	$270,169
Santa Cruz	513,268	$138,599
CalOPTIMA (Orange)	5,726,685	$1,415,157
Napa	225,027	$69,253
Monterey	1,167,051	$263,024
Yolo	389,721	$124,728
Sonoma	817,670	$246,672
Merced	1,017,064	$208,318
Marin	246,370	$92,485
Mendocino	272,472	$71,303
Ventura	1,456,817	$353,221
Del Norte	91,692	$29,026
Humboldt	325,146	$106,667
Lake	212,201	$65,717
Lassen	55,494	$18,083
Modoc	23,543	$11,118
Shasta	480,877	$166,388
Siskiyou	125,531	$37,296
Trinity	31,479	$10,081
Total FY 2014-15	16,283,239	$4,403,907
Mental Health Adjustment		-$110,607
AB 97 Adjustment		$14,408
Total with Adjustments		**$4,307,708**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 115

Funding:
(Dollars in Thousands)

FY 2013-14:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$3,889,587	$1,944,793	$1,944,794
State GF	4260-101-0001	$4,687	$4,687	$0
Family Planning 90/10 GF	4260-101-0001/0890	$20,169	$2,017	$18,152
Title XXI 65/35 GF	4260-113-0001/0890	$220,259	$77,091	$143,168
Total		**$4,134,702**	**$2,028,588**	**$2,106,114**

FY 2014-15:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$4,046,777	$2,023,388	$2,023,389
State GF	4260-101-0001	$4,752	$4,752	$0
Family Planning 90/10 GF	4260-101-0001/0890	$20,901	$2,090	$18,811
Title XXI 65/35 GF	4260-113-0001/0890	$235,278	$82,347	$152,931
Total		**$4,307,708**	**$2,112,577**	**$2,195,131**

GEOGRAPHIC MANAGED CARE

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,379,583,000	$1,619,755,000
- STATE FUNDS	$673,468,950	$792,586,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,379,583,000	$1,619,755,000
STATE FUNDS	$673,468,950	$792,586,600
FEDERAL FUNDS	$706,114,050	$827,168,400

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. Additionally, the Healthy Families Program (HFP) was transitioned into the Optional Targeted Low Income Children Program (OTLICP), which is accounted for in this policy change.

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. 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. IGT increases are budgeted in PC 118 Managed Care Rate Range IGTs.

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
   - Mental Health Increase
   - Diagnosis Related Groups

5. SB 78 applied a 3.9375% statewide tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.

6. Capitation rate increases due to 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 MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.

7. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Because these services are budgeted in PC 22 Mental Health Shift and Expansion, an adjustment was made to remove these dollars from this PC.

8. The savings from AB 97 are included in the rates. Because these savings are budgeted in PC 157 10% Provider Payment Reduction, an adjustment was made to restore those dollars in this PC.

9. 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.

10. The transition of the HFP into the OTLICP accounts for an additional 1,158,751 member months and $86.3 million in FY 2013-14, and 1,173,036 member months and $91.2 million in FY 2014-15. FY 2013-14 and 2014-15 OTLICP is budgeted at a FMAP split of 65/35 in the managed care model policy changes.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 116

(Dollars in Thousands)

FY 2013-14	Eligible Months	Total
Sacramento GMC	3,252,204	$595,359
San Diego GMC	4,271,803	$784,264
Total FY 2013-14	7,524,007	$1,379,623
Mental Health Adjustment		-$8,863
AB 97 Adjustment		$8,823
Total with Adjustments		**$1,379,583**

FY 2014-15	Eligible Months	Total
Sacramento GMC	3,334,826	$712,865
San Diego GMC	4,383,041	$930,365
Total FY 2014-15	7,717,867	$1,643,230
Mental Health Adjustment		-$35,381
AB 97 Adjustment		$11,906
Total with Adjustments		**$1,619,755**

Funding:

(Dollars in Thousands)

FY 2013-14:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$1,278,274	$639,137	$ 639,137
State GF	4260-101-0001	$ 2,917	$ 2,917	$ 0
Family Planning 90/10 FFP	4260-101-0001/0890	$ 12,089	$ 1,209	$ 10,880
Title XXI 65/35 FFP	4260-113-0001/0890	$ 86,303	$ 30,206	$ 56,097
Total		**$1,379,583**	**$673,469**	**$ 706,114**

FY 2014-15:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$1,513,177	$756,588	$ 756,589
State GF	4260-101-0001	$ 2,812	$ 2,812	$ 0
Family Planning 90/10 FFP	4260-101-0001/0890	$ 12,528	$ 1,253	$ 11,275
Title XXI 65/35 FFP	4260-113-0001-0890	$ 91,238	$ 31,933	$ 59,305
Total		**$1,619,755**	**$792,586**	**$ 827,169**

PACE (Other M/C)

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$193,351,000	$243,791,000
- STATE FUNDS	$96,675,500	$121,895,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$193,351,000	$243,791,000
STATE FUNDS	$96,675,500	$121,895,500
FEDERAL FUNDS	$96,675,500	$121,895,500

DESCRIPTION

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

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

Interdependent Policy Changes:
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:

PACE Organization	County	Operational
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	April 1, 2014
Central Valley Medical Svs.	Fresno	July 1, 2014
Redwood Coast	Humboldt	July 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.

5. The Department anticipates receiving final CMS approval of the revised 2013 PACE UPL in April 2014. This will result in a repayment to PACE organizations of approximately $3,109,000 for the increase of Medi-Cal Only and Dual rates that were paid at 2012 rates. This repayment is expected to occur during the May 2014 capitation cycle.

6. The Department will also recoup approximately $9,546,000 for the decrease of Medi-Cal Only and Dual rates that were paid at 2012 rates. The recoupment will begin with the May 2014 capitation cycle and is expected to be completed by the April 2015 capitation cycle.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 122

FY 2013-14	Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence	$30,571,000	7,321	610
Sutter Senior Care	$12,145,000	3,168	264
AltaMed Senior BuenaCare	$67,861,000	18,797	1,566
OnLok (SF, Alameda and Santa Clara)	$62,931,000	14,663	1,222
St. Paul's PACE	$15,109,000	4,196	350
Los Angeles Jewish Homes	$2,559,000	721	60
CalOptima PACE	$413,000	126	11
InnovAge	$244,000	70	6
Redwood Coast	$0	0	0
Central Valley Medical Services	$0	0	0
Total Capitation Payments	$191,833,000	49,062	4,089
2013 Rate Repayment	$3,109,000		
2013 Rate Recoupment	($1,591,000)		
Total FY 2013-14	**$193,351,000**		

FY 2014-15	Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence	$42,590,000	10,365	864
Sutter Senior Care	$13,016,000	3,390	283
AltaMed Senior BuenaCare	$78,493,000	21,671	1,806
OnLok (SF, Alameda and Santa Clara)	$70,741,000	16,626	1,385
St. Paul's PACE	$26,602,000	7,294	608
Los Angeles Jewish Homes	$5,775,000	1,647	137
CalOptima PACE	$3,046,000	917	76
InnovAge	$8,151,000	2,350	196
Redwood Coast	$1,451,000	380	32
Central Valley Medical Services	$1,881,000	516	43
Total Capitation Payments	$251,746,000	65,156	5,430
2013 Rate Recoupment	($7,955,000)		
Total FY 2014-15	**$243,791,000**		

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$66,037,000	$67,103,000
- STATE FUNDS	$33,018,500	$33,551,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$66,037,000	$67,103,000
STATE FUNDS	$33,018,500	$33,551,500
FEDERAL FUNDS	$33,018,500	$33,551,500

DESCRIPTION

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

Authority:
Social Security Act, Title XIX

Interdependent Policy Changes:
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 and Los Angeles 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 2013 to June 2013 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)

FY 2013-14		**Capitation Rate**	**Average Monthly Eligibles**	**Total Funds**
GMC				
	<21	$11.46	163,926	$22,543
	21+	$1.45	87,981	$1,531
PHP				
	<21	$11.46	290,684	$39,975
	21+	$1.45	114,242	$1,988
Total				**$66,037**
FY 2014-15				
GMC				
	<21	$11.46	169,709	$23,338
	21+	$1.45	91,085	$1,585
PHP				
	<21	$11.46	292,192	$40,182
	21+	$1.45	114,834	$1,998
Total				**$67,103**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$41,110,000	$41,232,000
- STATE FUNDS	$20,555,000	$20,616,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$41,110,000	$41,232,000
STATE FUNDS	$20,555,000	$20,616,000
FEDERAL FUNDS	$20,555,000	$20,616,000

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14200

Interdependent Policy Changes:
PC 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, 2012-13 and 2013-14 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 by 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 8,086 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

FY 2013-14	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	$26,118,000	61,461	5,122
Riverside	$7,611,000	19,617	1,635
San Bernardino	$5,281,000	12,461	1,038
Total	$39,010,000	93,539	7,795
2010-11 LTC Rate Recoupment	($17,300,000)		
2010-11 Aged/Disabled Rate Repayment	$8,700,000		
2012-13 Rate Adjustment	$10,700,000		
Total FY 2013-14	**$41,110,000**		
FY 2014-15			
Los Angeles	$27,617,000	63,553	5,296
Riverside	$8,050,000	20,301	1,692
San Bernardino	$5,565,000	12,838	1,070
Total	**$41,232,000**	96,692	8,058

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$9,582,000	$9,061,000
- STATE FUNDS	$4,791,000	$4,530,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,582,000	$9,061,000
STATE FUNDS	$4,791,000	$4,530,500
FEDERAL FUNDS	$4,791,000	$4,530,500

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 the overpayment on a monthly basis, retroactive to January 2012. The full recoupment is expected to be collected by June

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 129

2015.

AB 1422 (Chapter 157, Statues 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 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 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 rates and a delay of 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 $294.08 for FY 2013-14 and FY 2014-15.

4. Medi-Cal only capitation rates are assumed to be $1,664.04 for FY 2013-14 and FY 2014-15.

   Duals:
   FY 13/14: 4,200 x $294.08 = $1,235,000
   FY 14/15: 4,200 x $294.08 = $1,235,000

   Medi-Cal Only:
   FY 13/14: 5,400 x $1,664.04 = $8,986,000
   FY 14/15: 5,400 x $1,664.04 = $8,986,000

5. The total recoupment for calendar years 2012 and 2013 is estimated to be $639,000 in FY 2013-14 and $1,160,000 in FY 2014-15.

	FY 2013-14	FY 2014-15
Dual	$1,235,000	$1,235,000
Medi-Cal Only	$8,986,000	$8,986,000
Recoupment	-$639,000	-$1,160,000
Total	**$9,582,000**	**$9,061,000**

Funding:
50% Title XIX / 50% GF (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,510,000	$1,442,000
- STATE FUNDS	$755,000	$721,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,510,000	$1,442,000
STATE FUNDS	$755,000	$721,000
FEDERAL FUNDS	$755,000	$721,000

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 dropped from 1,405 to 817 in FY 2013-14, and from 1,465 to 780 in FY 2014-15.

Methodology:

1. Assume the member months will be 817 for FY 2013-14 and 780 for FY 2014-15.

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: 817 x $1,848.75 = **$1,510,000 TF ($755,000 GF)**

   FY 2014-15: 780 x $1,848.75 = **$1,442,000 TF ($721,000 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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,859,585,000	$3,259,927,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,859,585,000	$3,259,927,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,859,585,000	$3,259,927,000

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 Eligbles-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.

	TF	FFP	CDSS GF/ County Share
FY 2013-14	$5,719,170	**$2,859,585**	$2,859,585
FY 2014-15	$6,519,854	$3,259,927	$3,259,927

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,491,279,000	$2,575,216,000
- STATE FUNDS	$1,327,614,000	$1,372,957,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,491,279,000	$2,575,216,000
STATE FUNDS	$1,327,614,000	$1,372,957,500
FEDERAL FUNDS	$1,163,665,000	$1,202,258,500

DESCRIPTION

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

Reason for Change from Prior Estimate:
The Medicare 2014 premiums were released and the 2015 estimated premiums have been adjusted accordingly. Previously estimated premiums and this estimate are shown below with actual premiums:

	2013	2014		2015	
	Actual	November 2013 Estimate	Actual	November 2013 Estimate	May 2014 Estimate
Part A	$ 441.00	$ 444.90	$ 426.00	$ 448.80	$ 441.00
Part B	$ 104.90	$ 110.20	$ 104.90	$ 115.80	$ 110.20

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

BASE POLICY CHANGE NUMBER: 172

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. The Centers for Medicare and Medicaid set the 2014 Medicare Part A premium at $426.00 and the Medicare Part B premium at $104.90.

4. The 2015 Medicare Part A premium is estimated to increase by $15.00 to $441.00 and the Medicare Part B premium is estimated to increase by $5.30 to $110.20.

FY 2013-14	**Part A**	**Part B**
Average Monthly Eligibles	173,930	1,207,578
Rate 07/2013-12/2013	$441.00	$104.90
Rate 01/2014-06/2014	$426.00	$104.90
FY 2014-15		
Average Monthly Eligibles	177,485	1,234,383
Rate 07/2014-12/2014	$426.00	$104.90
Rate 01/2015-06/2015	$441.00	$110.20

Funding:

100% General Fund (4260-101-0001)
100% Title XIX (4260-101-0890)
50% Title XIX/50% General Fund (4260-101-0001/0890)

MEDICARE PAYMENTS - PART D PHASED-DOWN

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,475,883,000	$1,462,530,000
- STATE FUNDS	$1,475,883,000	$1,462,530,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,475,883,000	$1,462,530,000
STATE FUNDS	$1,475,883,000	$1,462,530,000
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 ⅔% 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:

Calendar Year	PMPM rate
2011	$100.77
2012	$102.76
2013	$103.70
2014	$97.40
2015	$99.13 (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:

Fiscal Year	Total Payment	Ave.Monthly Beneficiaries
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:

- Updated 2015 estimated PMPM growth. Prior estimate assumed a 2.46% annual increase. New CMS data adjusts the increase to 4.02%.
- Updated monthly dual eligible Part D enrollment.

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 estimated to increase 4.02% based on the adjusted 2014 estimated growth change from *Centers for Medicare & Medicaid Services.* Medi-Cal's estimated PMPM is $99.13.

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 2014 is received in February 2014 and payment is due in March 2014.

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly dual eligible Part D enrollment data from July 2008 – January 2014.

6. The Phased-down Contribution is funded 100% by State General Fund.

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2013-14	12	1,210,647	$122,990,292	**$1,475,883,000**
FY 2014-15	12	1,243,878	$121,877,463	**$1,462,530,000**

Funding:

100% GF (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,251,086,000	$1,406,132,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,251,086,000	$1,406,132,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,251,086,000	$1,406,132,000

DESCRIPTION

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

Authority:
Interagency Agreement 01-15834

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change from Prior Estimate:
The estimated amounts for FYs 2013-14 and 2014-15 have been revised to reflect updated data.

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

BASE POLICY CHANGE NUMBER: 174

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

(Dollars in Thousands)

	Total Funds	CDDS GF	DHCS FFP
FY 2013-14	$2,502,172	$1,251,086	**$1,251,086**
FY 2014-15	$2,812,264	$1,406,132	**$1,406,132**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$548,562,000	$578,288,000
- STATE FUNDS	$256,057,650	$267,310,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$548,562,000	$578,288,000
STATE FUNDS	$256,057,650	$267,310,900
FEDERAL FUNDS	$292,504,350	$310,977,100

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:
Estimate are revised based on additional months of actual data from August 2013 through December 2013. Also, costs for Optional Targeted Low-Income Children's Program (OTLICP) eligibles have been added to this policy change. In FY 2013-14 their costs are included in the FFS amounts while in FY 2014-15 they are included in the capitated eligibles. FY 2014-15 also includes some FSS amounts for OTLICP eligibles for services in FY 2013-14.

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 175

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.

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.

FY 2013-14	Rate	Average Monthly Eligibles	Total Funds
Regular 7/13 – 6/14	$5.74	6,652,887	$458,251,000
Refugee 7/13 – 6/14	$3.22	2,399	$93,000
Other FFS	Non-Capitated		$90,218,000
		Subtotal	$548,562,000
Underwriting Gain/Loss			$0
FY 2013-14 Dental Total			**$548,562,000**

FY 2014-15	Rate	Average Monthly Eligibles	Total Funds
Regular 7/14 – 6/15	$5.74	7,583,619	$522,360,000
Refugee 7/14 – 6/15	$3.22	2,601	$101,000
Other FFS	Non-Capitated		$55,827,000
FY 2014-15 Dental Total			**$578,288,000**

FY 2013-14	TF	GF	FF
Title XIX 65/35	$121,529,000	$42,535,000	$78,994,000
100% GF	$12,000	$12,000	$0
50/50 Title XIX	$427,021,000	$213,510,500	$213,510,500
Total	**$548,562,000**	**$256,057,500**	**$292,504,500**

FY 2013-14	TF	GF	FF
Title XIX 65/35	$145,594,000	$50,958,000	$94,636,000
100% GF	$12,000	$12,000	$0
50/50 Title XIX	$432,682,000	$216,341,000	$216,341,000
Total	**$578,288,000**	**$267,311,000**	**$310,977,000**

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:	Raman Pabla
FISCAL REFERENCE NUMBER:	77

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$261,000,000	$265,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$261,000,000	$265,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$261,000,000	$265,000,000

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

CASH BASIS (In Thousands)	**Total Funds**	**CDDS GF**	**FFP Regular**	**Interagency Agreement**
FY 2013-14	$521,000	$260,000	**$261,000**	03-75282 03-75283
FY 2014-15	$551,000	$265,000	**$265,000**	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:	Raman Pabla
FISCAL REFERENCE NUMBER:	26

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$157,313,000	$158,421,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$157,313,000	$158,421,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$157,313,000	$158,421,000

DESCRIPTION

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

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change from Prior Estimate:
The caseload has been updated.

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

BASE POLICY CHANGE NUMBER: 179

Methodology:

1. The following estimates have been provided by CDDS:

(In Thousands)

CASH BASIS	Total Funds	CDDS GF	DHCS FFP	IA #
FY 2013-14	$314,625	$157,312	**$157,313**	03-75284
FY 2014-15	$316,841	$158,420	**$158,421**	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

	FY 2013-14	FY 2014-15
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:
There is no change from prior estimate.

Methodology:
1. 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 average expenditures x (1 + 2% rate increase + 2% cost reconciliation) = $43,680,000

2. Payments for FY 2011-12 and FY 2012-13 cost reconciliation will be made in FY 2013-14.

3. 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.

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

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$26,039,000	$32,158,000
- STATE FUNDS	$13,019,500	$16,079,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$26,039,000	$32,158,000
STATE FUNDS	$13,019,500	$16,079,000
FEDERAL FUNDS	$13,019,500	$16,079,000

DESCRIPTION

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

Authority:
AB 668 (Chapter 896, Statutes of 1998)

Interdependent Policy Changes:
PC 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:
Costs have decreased based on updated actual utilization data.

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:	Stephanie Hockman
FISCAL REFERENCE NUMBER:	136

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$37,871,000	$38,799,000
- STATE FUNDS	$18,036,700	$18,478,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$37,871,000	$38,799,000
STATE FUNDS	$18,036,700	$18,478,650
FEDERAL FUNDS	$19,834,300	$20,320,350

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 649,328 x $58.32 (weighted average) = **$37,871,000** (rounded)

FY 2014-15
Screens 661,046 x $58.69 (weighted average) = **$38,799,000** (rounded)

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 182

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	188
IMPLEMENTATION DATE:	1/1993
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	91

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,384,000	$2,478,000
- STATE FUNDS	$1,192,000	$1,239,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,384,000	$2,478,000
STATE FUNDS	$1,192,000	$1,239,000
FEDERAL FUNDS	$1,192,000	$1,239,000

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:
As a result of the Department's migration from fee-for-service to managed care, costs are lower than projected due to a decrease in enrollment. In addition, the average monthly premium was higher than previously estimated as the transition towards managed care reduced the number of HIPP enrollees, yet retained enrollees with higher premiums. In FY 2014-15, health insurance premiums are expected to increase by 5%.

Methodology:
1. The average monthly premium cost is estimated to be $678.12 in FY 2013-14 and $712.03 in FY 2014-15.

2. The average monthly HIPP enrollment is estimated to be 293 in FY 2013-14 and 290 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: $678.12 x 293 x 12 Months = **$2,384,000 TF ($1,192,000 GF)**

FY 2014-15: $712.03 x 290 x 12 Months = **$2,478,000 TF ($1,239,000 GF)**

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	189
IMPLEMENTATION DATE:	7/1989
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	93

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,555,000	$7,865,000
- STATE FUNDS	$1,277,500	$3,932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,555,000	$7,865,000
STATE FUNDS	$1,277,500	$3,932,500
FEDERAL FUNDS	$1,277,500	$3,932,500

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 2013-14	Balance 2013-14	Budgeted 2013-14		Budgeted 2014-15	
Attorney Fees <$5,000	$8,161	$41,839	$50,000	*	$50,000	*
Provider Settlements <$75,000	$317,389	$1,282,611	$1,600,000	*	$1,600,000	*
Beneficiary Settlements <$2,000	$1,438	$13,562	$15,000	*	$15,000	*
Small Claims Court	$1,215	$198,785	$200,000	*	$200,000	*
Other Attorney Fees	$535,478	$6,000,000	$535,000	*	$6,000,000	
Other Provider Settlements	$0	N/A	$0		$0	
Other Beneficiary Settlements	$155,470	N/A	$155,000		$0	
	$1,019,151	$7,536,797	**$2,555,000**		**$7,865,000**	

* 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

	FY 2013-14	FY 2014-15
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:
This 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:
There is no change from prior estimate.

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) **FY 2013-14**	**DHCS FFP**	**CDPH CLPP Fee Funds**
Benefits Costs	**$1,799**	$1,799

FY 2014-15	**DHCS FFP**	**CDPH CLPP Fee Funds**
Benefits Costs	**$1,285**	$1,285

Funding:

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	202
IMPLEMENTATION DATE:	7/1987
ANALYST:	Jade Li
FISCAL REFERENCE NUMBER:	127

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$312,935,000	-$266,285,000
- STATE FUNDS	-$157,513,000	-$134,032,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$312,935,000	-$266,285,000
STATE FUNDS	-$157,513,000	-$134,032,000
FEDERAL FUNDS	-$155,422,000	-$132,253,000

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:
Increased recoveries in FY 2013-14 are due to one-time provider audit collections.

Methodology:
1. The recoveries estimate uses the trend in the monthly recoveries for July 2010 – Feb 2014.

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)

Estimated Base Recoveries	FY 2013-14	FY 2014-15
Personal Injury Collections	($51,763)	($52,368)
Workers' Comp. Contract	($2,189)	($2,826)
H.I. Contingency Contract	($63,063)	($60,000)
General Collections	($195,920)	($151,091)
TOTAL	**($312,935)**	**($266,285)**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$27,050,000	-$27,050,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$27,050,000	-$27,050,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$27,050,000	-$27,050,000

DESCRIPTION

Purpose:
This policy change estimates the savings associated with the closure of Drug Medi-Cal (DMC) provider facilities that were temporarily 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 2013. As of March 18, 2014, the Department has issued temporary suspensions for 235 sites out of the 1,573 certified DMC providers. In addition, the Department has lodged 89 Credible Allegations of Fraud with the California Department of Justice for potential prosecution. The billings from these temporarily suspended providers totaled $54.1 million of the $198.9 million in approved DMC billings for FY 2012-13. This represents 27% of the expenditures of the program.

Reason for Change from Prior Estimate:
This policy change has been updated with seven months of additional data.

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	($54,100,000)	($26,509,000)	($541,000)	($27,050,000)
TOTAL FY 2013-14	($54,100,000)	**($26,509,000)**	**($541,000)**	($27,050,000)

Cash Estimate	TF	FFP Title XIX	FFP Title XXI	CF
FY 2013-14	($54,100,000)	($26,509,000)	($541,000)	($27,050,000)
TOTAL FY 2014-15	($54,100,000)	**($26,509,000)**	**($541,000)**	($27,050,000)

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER:	215
IMPLEMENTATION DATE:	11/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1842

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$182,120,000	$300,253,000
- STATE FUNDS	$88,529,200	$145,419,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$182,120,000	$300,253,000
STATE FUNDS	$88,529,200	$145,419,200
FEDERAL FUNDS	$93,590,800	$154,833,800

DESCRIPTION

Purpose:
This policy change estimates the managed care capitation costs for the Regional model plans.

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 was previously in 30 counties. AB 1467 expanded 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 coordinated their care and leads to better health outcomes and lower costs.

There are 20 counties in the regional model: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

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

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 rebasing process includes refreshed data and adjustments to trends.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 215

2. SB 78 applied a 3.9375% statewide tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.

3. Capitation rate increases due to 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 MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.

4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Because these services are budgeted in PC 22 Mental Health Shift and Expansion, an adjustment was made to remove these dollars from this PC.

5. The savings from AB 97 are included in the rates. Because these savings are budgeted in PC 157 10% Provider Payment Reduction, an adjustment was made to restore those dollars in this PC.

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.

7. FY 2013-14 and 2014-15 OTLICP (Optional Targeted Low Income Children Program) is budgeted at a FMAP split of 65/35 in the managed care model policy changes.

8. This policy change includes a one-month deferral in FY 2013-14.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 215

(Dollars in Thousands)

FY 2013-14	Eligible Months	Total
Alpine	762	$140
Amador	22,395	$2,953
Butte	247,426	$35,940
Calaveras	33,628	$4,366
Colusa	31,448	$3,688
El Dorado	97,328	$12,834
Glenn	42,731	$5,610
Inyo	17,104	$2,323
Mariposa	13,984	$1,907
Mono	9,187	$1,085
Nevada	66,522	$8,800
Placer	160,687	$20,909
Plumas	13,746	$1,851
Sierra	2,043	$259
Sutter	133,645	$17,262
Tehama	87,715	$11,871
Tuolumne	40,507	$5,337
Yuba	102,106	$13,469
Imperial	327,364	$46,405
San Benito	49,601	$6,170
Total FY 2013-14	1,499,929	$203,179
Mental Health Adjustment		$(2,164)
AB 97 Adjustment		$2,694
BCCTP Adjustment		$4,662
Total with Adjustments		**$208,371**
Deferral		$(26,251)
Total		**$182,120**

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 215

(Dollars in Thousands)

FY 2014-15	Eligible Months	Total
Alpine	1,167	$193
Amador	33,941	$4,339
Butte	374,133	$53,114
Calaveras	50,984	$6,571
Colusa	46,988	$5,524
El Dorado	147,722	$19,393
Glenn	64,310	$8,409
Inyo	25,767	$3,438
Mariposa	21,134	$2,834
Mono	13,806	$1,642
Nevada	100,359	$13,030
Placer	243,548	$30,940
Plumas	20,856	$2,775
Sierra	3,050	$382
Sutter	202,141	$26,006
Tehama	132,715	$17,787
Tuolumne	61,345	$8,097
Yuba	154,670	$20,576
Imperial	498,537	$68,755
San Benito	73,526	$8,794
Total FY 2014-15	2,270,699	$302,599
Mental Health Adjustment		$(11,922)
AB 97 Adjustment		$4,752
BCCTP Adjustment		$4,824
Total with Adjustments		**$300,253**

Funding:

(Dollars in Thousands)

FY 2013-14

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$165,248	$82,624	$82,624
Family Planning 90/10 GF	4260-101-0001/0890	$0	$0	$0
Title XXI 65/35 GF	4260-113-0001/0890	$16,872	$5,905	$10,967
Total		**$182,120**	**$88,529**	**$93,591**

FY 2014-15		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$268,871	$134,435	$134,436
Family Planning 90/10 GF	4260-101-0001/0890	$0	$0	$0
Title XXI 65/35 GF	4260-113-0001/0890	$31,382	$10,984	$20,398
Total		**$300,253**	**$145,419**	**$154,834**

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2	FAMILY PACT PROGRAM
3	BREAST AND CERVICAL CANCER TREATMENT
4	AIM LINKED INFANTS 250-300% FPL
5	MEDI-CAL ADULT INMATE PROGRAMS
7	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES
8	REFUGEES
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
	AFFORDABLE CARE ACT
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
34	MANAGED CARE DRUG REBATES
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210	ACA EXPANSION-PREGNANCY ONLY '
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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
49	SCHIP FUNDING FOR PRENATAL CARE
50	COPAYMENT FOR NON-EMERGENCY ER VISITS
51	WOMEN'S HEALTH SERVICES
52	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS
66	VOLUNTARY INPATIENT DETOXIFICATION
208	DENTAL CHILDREN'S OUTREACH AGES 0-3
	PHARMACY
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
211	MCO SUPPLEMENTAL DRUG REBATE
219	VISION OUTREACH
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67	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
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POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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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	IMD ANCILLARY SERVICES
81	CHART REVIEW
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	WAIVER--MH/UCD & BTR
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
97	MH/UCD & BTR—DPH INTERIM RATE GROWTH
98	BTR—INCREASE SAFETY NET CARE POOL
99	MH/UCD—STABILIZATION FUNDING
100	MH/UCD & BTR—DPH INTERIM & FINAL RECONS
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
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POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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108	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
110	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
112	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS
113	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY
	MANAGED CARE
117	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES
118	MANAGED CARE RATE RANGE IGTS
119	CCI-MANAGED CARE PAYMENTS
120	MANAGED CARE PUBLIC HOSPITAL IGTS
121	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES
123	CCI-TRANSFER OF IHSS COSTS TO CDSS
124	RETRO MC RATE ADJUSTMENTS
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128	INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX
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133	FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF
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135	MANAGED CARE IGT ADMIN. & PROCESSING FEE
136	GENERAL FUND REIMBURSEMENTS FROM DPHS
137	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
138	FFS COSTS FOR MANAGED CARE ENROLLEES
139	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
140	MCO TAX MANAGED CARE PLANS
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143	CCI-SAVINGS AND DEFERRAL
	PROVIDER RATES
24'	AB 1629 ADD-ONS
144'	FQHC/RHC/CBRC RECONCILIATION PROCESS
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POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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146	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
147	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
148	LTC RATE ADJUSTMENT
149	ANNUAL MEI INCREASE FOR FQHCS/RHCS
150	HOSPICE RATE INCREASES
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
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	SUPPLEMENTAL PMNTS.
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160	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
161	GEMT SUPPLEMENTAL PAYMENT PROGRAM
162	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
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164	CERTIFICATION PAYMENTS FOR DP-NFS
165	CAPITAL PROJECT DEBT REIMBURSEMENT
166	FFP FOR LOCAL TRAUMA CENTERS
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178	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
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POLICY CHANGE INDEX

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187	AUDIT SETTLEMENTS
191	INDIAN HEALTH SERVICES
192	CIGARETTE AND TOBACCO SURTAX FUNDS
194	CLPP FUND
195	HOSPITAL QAF - CHILDREN'S HEALTH CARE
197	CCI-TRANSFER OF IHSS COSTS TO DHCS
198	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
201	IHSS REDUCTION IN SERVICE HOURS
216	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

FAMILY PACT PROGRAM

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$576,793,000	$587,160,000
- STATE FUNDS	$144,468,000	$147,064,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$576,793,000	$587,160,000
STATE FUNDS	$144,468,000	$147,064,500
FEDERAL FUNDS	$432,325,000	$440,095,500

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 the 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:
Updated expenditure data through January 2014.

Methodology:
1. Use linear regressions on actual data from September 2010 to January 2014 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.

	FY 2013-14		FY 2014-15	
Service Category	**TF**	**GF**	**TF**	**GF**
Physicians	$90,527,000	$22,674,000	$98,939,000	$24,781,000
Other Medical	$341,499,000	$85,534,000	$343,393,000	$86,009,000
County Outpatient	$1,628,000	$408,000	$1,296,000	$324,000
Community Outpatient	$4,644,000	$1,163,000	$4,770,000	$1,195,000
Pharmacy	$138,495,000	$34,688,000	$138,762,000	$34,755,000
Total	**$576,793,000**	**$144,467,000**	**$587,160,000**	**$147,064,000**

Funding:

(Dollars in Thousands)

FY 2013-14:

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$35,930	$17,965	$17,965
100% GF	4260-101-0001	$80,463	$80,463	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$460,400	$46,040	$414,360
Total		**$576,793**	**$144,468**	**$432,325**

FY 2014-15:

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$36,576	$18,288	$18,288
100% GF	4260-101-0001	$81,909	$81,909	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$468,675	$46,868	$421,807
Total		**$587,160**	**$147,065**	**$440,095**

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	1/2002
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	3

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$149,256,000	$159,874,000
- STATE FUNDS	$65,896,100	$69,940,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$149,256,000	$159,874,000
STATE FUNDS	$65,896,100	$69,940,000
FEDERAL FUNDS	$83,359,900	$89,934,000

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 (65% FFP/35% GF) 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 65 years of age who are citizens or legal immigrants with no other health coverage.

A State-Only program covers women 65 years of age 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 the Centers for Disease Control (CDC) and Family Planning, Access, Care, and Treatment (Family PACT) providers.

Reason for Change from Prior Estimate:
Updated eligibles data from September 2013 through January 2014 and updated expenditures data from July 2013 through December 2013.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

Methodology:

1. There were 10,119 FFS and 3,263 managed care eligibles as of December 2013 (total of 13,382). 2,395 of the FFS eligibles were eligible for State-Only services.

2. 576 of the FFS eligibles were in Accelerated Enrollment as of December 2013.

3. Assume the State will pay Medicare and other health coverage premiums for an average of 483 beneficiaries monthly in FY 2013-14 and FY 2014-15. Assume an average monthly premium cost per beneficiary of $219.84.

   FY 2013-14: 483 x $219.84 x 12 months = $1,274,000* TF ($1,274,000 GF) *Rounded
   FY 2014-15: 483 x $219.84 x 12 months = $1,274,000* TF ($1,274,000 GF) *Rounded

4. FFS costs are estimated as follows:

(Dollars in Thousands)

	FY 2013-14		FY 2014-15	
	TF	**GF**	**TF**	**GF**
Federally Funded-Costs	$128,246	$44,886	$138,360	$48,426
State-Only Costs				
Services	$19,736	$19,736	$20,240	$20,240
Premiums	$1,274	$1,274	$1,274	$1,274
Total	**$149,256**	**$65,896**	**$159,874**	**$69,940**

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:

(Dollars in Thousands)

FY 2013-14:		**GF**	**FF**	**TF**
General Fund	4260-101-0001	$21,010	$0	$21,010
65% Title XIX / 35% GF	4260-101-0001/0890	$44,886	$83,360	$128,246
Total		**$65,896**	**$83,360**	**$149,256**

FY 2014-15:		**GF**	**FF**	**TF**
General Fund	4260-101-0001	$21,514	$0	$21,514
65% Title XIX / 35% GF	4260-101-0001/0890	$48,426	$89,934	$138,360
Total		**$69,940**	**$89,934**	**$159,874**

AIM LINKED INFANTS 250-300% FPL

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$31,629,000	$33,232,000
- STATE FUNDS	$11,070,150	$11,631,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,629,000	$33,232,000
STATE FUNDS	$11,070,150	$11,631,200
FEDERAL FUNDS	$20,558,850	$21,600,800

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 transitioned 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:
MRMIB provided updated estimated costs for FY 2013-14 and FY 2014-15.

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.

AIM LINKED INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER: 4

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

(In Thousands)	TF	GF	FF
FY 2013-14	**$31,629**	**$11,070**	**$20,559**

(In Thousands)	TF	GF	FF
FY 2014-15	**$33,232**	**$11,631**	**$21,601**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$14,092,000	$27,477,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,092,000	$27,477,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$14,092,000	$27,477,000

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)
AB 720 (Chapter 646, Statutes of 2013)
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. 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, 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.

AB 720 (Chapter 646, Statutes of 2013) authorizes the board of supervisors in each county, in consultation with the county sheriff, to designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program. This bill authorizes the entity to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services as specified.

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

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.

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 based on actual utilization claims and FY 2010-11 retro dollars added for FY 2014-15.

Methodology:

1. This program for the State and county inmates began in November 2010. For the State inmates, eligibility began in April 2011 with claiming beginning in April 2012. For the county inmates, eligibility and claiming began in January 2014.

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 utilization claims information, the average cost for an adult inpatient admission is $12,111 for both State and county inmates.

4. It is assumed the Department will process 300 applications per month for State inmates with verified citizenship.

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

   300 monthly applications x 96% = 288 eligible State inmates

6. Of the 288 eligible State inmates, it is assumed 20% are for Non-ACA Medi-Cal and 80% will fall under the LIPH or the ACA Optional Expansion Medi-Cal population.

Monthly Applications	FY 2013-2014					FY 2014-15				
Adults –Non ACA	288	x	20%	=	58	288	x	20%	=	58
Adults- ACA	288	x	80%	=	230	288	x	80%	=	230

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

7. State inmate inpatient costs are estimated to be $8,429,000 ($4,214,500 GF) in FY 2013-14 and FY 2014-15.

   58 monthly applications x 12 months x $12,111 = $8,429,000 (rounded)

8. It is assumed that there are 74,000 monthly county adult inmates. Of these it is assumed that 2% will utilize inpatient services on a monthly basis and, of these, 20% will be eligible for Medi-Cal or LIPH.

   74,000 monthly county adult inmates x 2% x 20% = 296 county applications

9. Assumes for FY 2013-14, July –December, the county application split will be 20% for Medi-Cal and 80% LIPH; from January –June, LIPH will be phase out and all applications will be Medi-Cal.

   296 county applications x 20% = 59 eligible county inmates

10. County inmate inpatient inmate costs are estimated to be $8,575,000 for FY 2013-14. However, for FY 2014-15, the FY 2010-11 retro claims will be paid and the county inmate inpatient costs are estimated to be $33,575,000 TF ($8,575,000 + $25,000.00 retro claims).

FY 2013-14 (Rounded)							**TF**	**FF**
Adults	59	x	12	x	$12,111	=	$8,575,000	$4,287,000
Total							**$8,575,000**	**$4,287,000**

FY 2014-15							**TF**	**FF**
Adults	59	x	12	x	$12,111	=	$8,575,000	$4,287,000
FY 2010-11 retro claims							$25,000,000	$12,500.000
Total							**$33,575,000**	**$18,150,000**

11. 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 fifteen months of continuous coverage.

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

FY 2013-14
(Rounded)

LTC Eligible Months		PMPM		**TF**	**FF**
344*	x	8,019	=	**$2,759,000**	**$1,379,000**

FY 2014-15

LTC Eligible Months		PMPM		**TF**	**FF**
375	x	$8,019	=	**$3,007,000**	**$1,503,500**

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

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 5

13. 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.

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

FY 2013-14

LTC Eligible Months		PMPM		TF	FF
1050*	x	$8,019	=	**$8,420,000**	**$4,210,000**

FY 2014-15

LTC Eligible Months		PMPM		TF	FF
900	x	$8,019	=	**$7,217,000**	**$3,608,500**

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

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

(In Thousands-Rounded)

Summary	**FY 2013-14**		**FY 2014-15**	
State	**TF**	**FF**	**TF**	**FF**
Adults	$8,429,000	$4,214,500	$8,429,000	$4,214,500
Medical Parole	$2,759,000	$1,379,500	$3,007,000	$1,503,500
Total	$11,188,000	$5,594,000	$11,436,000	$5,718,000
County				
Adults	$8,575,000	$4,287,500	$33,575,000	$18,150,000
Compassionate Release/ Probation	$8,420,000	$4,210,000	$7,217,000	$3,608,000
Total	$16,995,000	$8,497,500	$40,792,000	$21,758,500
State/County Total	$28,183,000	**$14,092,000**	$52,228,000	**$27,477,000**

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

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,518,000	$5,469,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,518,000	$5,469,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,518,000	$5,469,000

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)
AB 720 (Chapter 646, Statutes of 2013)

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.

AB 720 (Chapter 646, Statutes of 2013) authorizes the board of supervisors in each county, in consultation with the county sheriff, to designate an entity or entities to assist county jail inmates to apply for a health insurance affordability program. This bill authorizes the entity to act on behalf of a county jail inmate for the purpose of applying for, or determinations of, Medi-Cal eligibility for acute inpatient hospital services as specified.

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.

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 7

Reason for Change from Prior Estimate:
FY 2011-12 retroactive claims for the county juvenile inmate program will be paid in FY 2014-15. There was also a reduction in the annual potentially eligible State juveniles based on CDCR projections.

Methodology:

1. Program began in January 2012 and claiming began in April 2013.

2. Applications for Medi-Cal will be processed by the Department if the applicant received off-site 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 $9,326. Based on the Mental Health Services Division information, $6,297 is the average inpatient psychiatric admission for those under 21 years old.

4. It is assumed the Department will process 10 applications per month for State juveniles and 99 applications per month for county juveniles with verified citizenship.

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

State Inmates	**FY 2013-14 & FY 2014-15**				
Psychiatric Services	10	x	80%	=	**8**
Inpatient Services	10	x	20%	=	**2**

(Rounded)

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

6. State juvenile costs are estimated to be $829,000 TF ($414,500 GF) in FY 2013-14 and in FY 2014-15.

FY 2013-14 (Rounded)							**TF**	**FF**
Psychiatric Services	8	x	12	x	$6,297	=	$605,000	$302,500
Inpatient Services	2	x	12	x	$9,326	=	$224,000	$112,000
Total							**$829,000**	**$414,500**

FY 2014-15							**TF**	**FF**
Psychiatric Services	8	x	12	x	$6,297	=	$605,000	$302,000
Inpatient Services	2	x	12	x	$9,326	=	$224,000	$112,500
Total							**$829,000**	**$414,500**

7. Implementation of the county juvenile inmate program began January 1, 2012; however, the FY 2011-12 claims will not be reimbursed until FY 2014-15. County juvenile inmate costs are estimated to be $10,108,000 TF ($8,208,000 TF + $1,900,000 retroactive claims) in FY 2014-15.

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 7

(Rounded)

FY 2013-14								TF	FF
Psychiatric Services	79	x	12	x	$6,297	=		$5,970,000	$2,985,000
Inpatient Services	20	x	12	x	$9,326	=		$2,238,000	$1,119,000
Total								**$8,208,000**	**$4,104,000**

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

(Rounded)

FY 2014-15									
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	$9,326	=		$2,238,000	$1,119,500
Total								**$10,108,000**	**$5,054,500**

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

(Rounded)

	FY 2013-14		FY 2014-15	
Summary	**TF**	**FF**	**TF**	**FF**
State	$829,000	$414,500	$829,000	$414,500
County	$8,208,000	$4,104,000	$10,108,000	$5,054,500
Total	$9,037,000	**$4,518,000**	$10,937,000	**$5,469,000**

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

REFUGEES

REGULAR POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	7/1980
ANALYST:	Toni Richardson
FISCAL REFERENCE NUMBER:	14

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,878,000	$5,844,000
- STATE FUNDS	$5,878,000	$5,844,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,878,000	$5,844,000
STATE FUNDS	$5,878,000	$5,844,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

Authority:
Interagency Agreement #12-10028

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

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

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

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

Methodology:
1. Total refugee expenditures to be reimbursed by CDPH are estimated to be $5,878,000 in FY 2013-14 and $5,844,000 in FY 2014-15.

REFUGEES

REGULAR POLICY CHANGE NUMBER: 8

Funding:
100% Reimbursement (4260-610-0995)

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1823

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$1,726,000
- STATE FUNDS	$0	$604,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,726,000
STATE FUNDS	$0	$604,000
FEDERAL FUNDS	$0	$1,122,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Currently, the CHIM program is in three counties (San Francisco, San Mateo, and Santa Clara) and is monitored by the Managed Risk Medical Insurance Board (MRMIB). To be eligible for the CHIM program, children must be under the age of 19 years old and have a household income between 250% and 300% of the federal poverty level (FPL). Effective July 1, 2014, children participating in the CHIM program will transition into the Medi-Cal delivery system.

Reason for Change from Prior Estimate:
Santa Clara County did not expand to the 400% FPL and remained at 300%.

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

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

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER: 10

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

(In Thousands)	TF	SF	FF
Title XXI FFP	$1,122	$0	$1,122
Title XXI GF	$389	$389	$0
CHIM Fund	$215	$215	$0
FY 2014-15	**$1,726**	**$604**	**$1,122**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$62,996,000	$63,324,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$62,996,000	$63,324,000
FEDERAL FUNDS	-$62,996,000	-$63,324,000

DESCRIPTION

Purpose:
This policy change is a technical adjustment to shift funds from Title XIX 50% federal financial participation (FFP) to 100% general fund (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 five 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 new FFS data from July 2013- December 2013.

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

2. Based on the historical pattern of FFS versus managed care nonemergency service expenditures

NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 11

for the period of June 2010 through July 2011 (19.27%), the managed care totals for current year and budget year were projected.

3. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified 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 NQIs, who are children or pregnant women, is budgeted in the CHIPRA Medi-Cal for Children and Pregnant Women policy change.

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

(Dollars In Thousands)	**FY 2013-14**	**FY 2014-15**
FFS	$105,633	$106,183
Managed Care	$20,359	$20,465
Total	$125,992	$126,648
FFP Repayment	**$62,996**	**$63,324**

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

RESOURCE DISREGARD - % PROGRAM CHILDREN

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$86,060,700	-$86,018,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$86,060,700	-$86,018,250
FEDERAL FUNDS	$86,060,700	$86,018,250

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable.

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

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

Reason for Change from Prior Estimate:
The estimated total managed care capitation for aid codes 8P and 8R increased from $273,000,000 to $456,000,000 in FY 2013-14 and $281,000,000 to $453,000,000 in FY 2014-15. Correspondingly, the monthly estimated eligibles increased from 206,000 to 227,000 in FY 2013-14 and 211,000 to 231,000 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 50,678 in FY 2013-14 and 52,289 in FY 2014-15. It is assumed total FFS expenditures will be $41,100,000 in FY 2013-14 and $42,400,000 in FY 2014-15.

3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 227,000 in FY 2013-14 and 231,000 in FY 2014-15. It is assumed total Managed Care expenditures will be $532,600,000 in FY 2013-14 and $531,000,000 in FY 2014-15.

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

Funding:

(Dollars in Thousands)

FY 2013-14		**TF**	**GF**	**FF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($573,738)	($286,869)	($286,869)
65 % Title XXI /35 % GF	4260-113-0001/0890	$573,738	$200,808	$372,930
Net Impact (rounded)		$0	**($86,061)**	$86,061

FY 2014-15		**TF**	**FF**	**GF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($573,455)	($286,728)	($286,728)
65 % Title XXI /35 % GF	4260-113-0001/0890	$573,455	$200,709	$372,746
Net Impact (rounded)		$0	**($86,018)**	$86,018

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$8,927,700	-$8,949,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$8,927,700	-$8,949,550
FEDERAL FUNDS	$8,927,700	$8,949,550

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 children and pregnant immigrants 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 Immigrants” if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible qualified Immigrants who have been in the US for less than five years and pays for nonemergency services with 100% State funds. Immigrants who are New Qualified Immigrants (NQIs) are eligible for state funded full-scope Medi-Cal if they have a satisfactory immigration status even though they have not been in the United States for five years. FFP is only available for NQIs 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 NQIs 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 NQI 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:
Additional actuals for July 2013 – December 2013; updated children data reports for calendar year (CY) 2012.

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. Children

   Based upon quarterly claiming reports for 2013, 34.70% of expenditures for NQI services are for non-emergency services.

   FFS:
   Data reports for NQI children for CY 2012 services show fee-for-service (FFS) costs (including managed care carve-outs) of $9,693,000 for 0 to 18 year olds and $2,697,000 for 19 and 20 year olds.

   Non-emergency FFS expenditures for NQI children are:
   $9,693,000 x 34.70% non-emergency = $3,363,500 (0 to 18 year olds)
   $2,697,000 x 34.70% non-emergency = $935,900 (19 and 20 year olds)

   Managed Care:
   Data reports of NQI children managed care eligibles for calendar 2012 show 171,845 eligible months for 0 to 18 year olds and 14,867 for 19 and 20 year olds.

   The average capitation for the NQI children and pregnant women is assumed to be $115.92 PMPM in FY 2013-14 and $116.42 in FY 2014-15.

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

   171,628 eligible months x $115.92 PMPM x 34.70% non-emergency = $6,903,600 (0 to 18 year olds) for FY 2013-14 and 171,628 eligible months x $116.42 PMPM x 34.70% non-emergency = $6,933,400 for FY 2014-15.

   14,594 eligible months x $115.92 PMPM x 34.70 % non-emergency = $587,000 (19 and 20 year olds) for FY 2013-14 and 14,594 eligible months x $116.42 PMPM x 34.70 % non-emergency = $589,600 for FY 2014-15.

3. Pregnant Women

   Based on expenditure data for pregnant women, 6.64% of expenditures are for non-pregnancy related services.

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

   The non-pregnancy related FFS expenditures for pregnant women are:
   $34,926,000 x 6.64% = $2,319,000 for both FY 2013-14 and 2014-15.

   Managed Care:
   Reports of NQI pregnant eligibles for CY 2012 show 86,471 eligible months.

   The average capitation for pregnant women is assumed to be $115.92 PMPM for FY 2013-14 and $116.42 for FY 2014-15.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

Non-pregnancy services = 86,471 eligible months x $115.92 PMPM x 6.64% = $665,600 for FY 2013-14 and 86,471 eligible months x $116.42 PMPM x 6.64% = $668,400 for FY 2014-15.

(Rounded)	FY 2013-14		FY 2014-15	
	Title XIX (50/50)	**Title XXI (65/35)**	**Title XIX (50/50)**	**Title XXI (65/35)**
Children (0-18)				
FFS	$0	$3,364,000	$0	$3,364,000
MC	$0	$6,903,000	$0	$6,933,000
Children (19-20)				
FFS	$936,000	$0	$936,000	$0
MC	$587,000	$0	$590,000	$0
Pregnant Women				
FFS	$2,319,000	$0	$2,319,000	$0
MC	$666,000	$0	$669,000	$0
Total	$4,508,000	$10,267,000	$4,514,000	$10,297,000
GF	$2,254,000	$3,593,000	$2,257,000	$3,604,000
FFP	**$2,254,000**	**$6,674,000**	**$2,257,000**	**$6,693,000**

4. Total FY 2013-14 FFP of $8,928,000 offsets the General Fund cost of providing services to these eligibles.

5. Total FY 2014-15 FFP of $8,950,000 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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$255,000	-$573,000
- STATE FUNDS	-$127,500	-$286,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	61.70 %	27.20 %
APPLIED TO BASE		
TOTAL FUNDS	-$97,700	-$417,100
STATE FUNDS	-$48,830	-$208,570
FEDERAL FUNDS	-$48,830	-$208,570

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:
There are additional discontinued managed care beneficiaries and more FY 2013-14 dollars in the base.

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 a total of 375 managed care beneficiaries will be discontinued from Medi-Cal in FY 2013-14 and FY 2014-15.

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 14

3. Total managed care savings is estimated to be $255,000 TF in FY 2013-14, and $573,000 TF in FY 2014-15.

4. In FY 2013-14, it is estimated that 61.70% of the managed care savings is captured in the base trends. In FY 2014-15, it is estimated that 27.20% of the managed care savings is captured in the base trends.

FY 2013-14	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($255,000)**	61.70%	($157,000)

FY 2014-15	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($573,000)**	27.20%	($156,000)

5. Total estimated savings not in the base trends:

FY 2013-14	**TF**	**GF**
Total Savings	**($98,000)**	**($48,500)**

FY 2014-15	**TF**	**GF**
Total Savings	**($417,000)**	**($209,000)**

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

PARIS-FEDERAL

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$10,470,000	-$15,826,000
- STATE FUNDS	-$5,235,000	-$7,913,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	90.87 %	77.18 %
APPLIED TO BASE		
TOTAL FUNDS	-$955,900	-$3,611,500
STATE FUNDS	-$477,960	-$1,805,750
FEDERAL FUNDS	-$477,960	-$1,805,750

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:
Statewide implementation has increased the level of ongoing matches higher than previously estimated.

Methodology:
1. Savings for PARIS-Federal is assumed for both Managed Care and FFS.

2. Based on quarterly reports from May 2013 through August 2013, it is estimated 621 managed care and 145 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 $2,508,000 TF in FY 2013-14, and $3,791,000 TF in FY 2014-15. Total FFS savings is estimated to be $7,962,000 TF in FY 2013-14 and $12,035,000 TF in FY 2014-15.

4. In FY 2013-14, it is estimated that 90.87% of the managed care and FFS savings is captured in the base trends. In FY 2014-15, it is estimated that 77.18% of the managed care and FFS savings is captured in the base trends.

FY 2013-14	Total Savings	% in Base	Savings in Base
Managed Care Savings	($2,508,000)	90.87%	($2,279,000)
FFS Savings	($7,962,000)	90.87%	($7,236,000)
Total	**($10,470,000)**		**($9,515,000)**

FY 2014-15	Total Savings	% in Base	Savings in Base
Managed Care Savings	($3,791,000)	77.18%	($2,926,000)
FFS Savings	($12,035,000)	77.18%	($9,288,000)
Total	**($15,826,000)**		**($12,214,000)**

5. Total estimated savings not in the base trends:

FY 2013-14	TF	GF
Managed Care Savings	($229,000)	($115,000)
FFS Savings	($726,000)	($363,000)
Total	**($955,000)**	**($478,000)**

FY 2014-15	TF	GF
Managed Care Savings	($865,000)	($433,000)
FFS Savings	($2,747,000)	($1,373,000)
Total	**($3,612,000)**	**($1,806,000)**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$2,720,000	-$4,215,000
- STATE FUNDS	-$1,360,000	-$2,107,500
PAYMENT LAG	0.9344	0.9589
% REFLECTED IN BASE	49.81 %	63.67 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,275,600	-$1,468,400
STATE FUNDS	-$637,810	-$734,190
FEDERAL FUNDS	-$637,810	-$734,190

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:
There was an adjustment in the FY 2012-13 overlap savings and a shift in the types of beneficiaries' discontinuances.

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 101 veterans in FY 2013-14 and FY 2014-15, of which 59 will be managed care and 42 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. Monthly savings was calculated by dividing the annual discontinuances by the quarters and then multiplying the managed care weighted average cap rates and the fee for service average costs with the corresponding discontinuances.

5. Average savings on a PMPM basis will be $316.84 in FY 2013-14 and $301.22 in FY 2014-15. This decrease is a result of the shifting of discontinuances from the higher cost long term care to other lower cost medically needy aged, disabled, and families' beneficiaries.

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$23,631,000	-$32,216,000
- STATE FUNDS	-$11,815,500	-$16,108,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	94.49 %	84.34 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,302,100	-$5,045,000
STATE FUNDS	-$651,030	-$2,522,510
FEDERAL FUNDS	-$651,030	-$2,522,510

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:
Actuals for the November 2012- May 2013 matches were lower than estimated.

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 5,995 managed care beneficiaries will be discontinued from Medi-Cal in FY 2013-14, and 6,040 in FY 2014-15.

3. Total managed care savings is estimated to be $23,631,000 TF in FY 2013-14, and $32,216,000 TF in FY 2014-15.

4. In FY 2013-14, it is estimated that 94.49% of the managed care savings is captured in the base trends. In FY 2014-15, it is estimated that 84.34% of the managed care savings is captured in the base trends.

(Rounded)

FY 2013-14	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($23,631,000)**	94.49%	($22,329,000)

FY 2014-15	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($32,216,000)**	84.34%	($27,171,000)

5. Total estimated savings not in the base trends:

(Rounded)

FY 2013-14	**TF**	**GF**
Total Savings	**($1,302,000)**	**($651,000)**

FY 2014-15	**TF**	**GF**
Total Savings	**($5,045,000)**	**($2,522,500)**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,857,646,000	$12,553,609,000
- STATE FUNDS	$1,768,000	$6,283,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,857,646,000	$12,553,609,000
STATE FUNDS	$1,768,000	$6,283,000
FEDERAL FUNDS	$2,855,878,000	$12,547,326,000

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
PC 38 Restoration of Select Adult Dental Benefits

Background:
Effective January 1, 2014, the ACA expands 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 Department revised the caseload projections based on enrollment data through mid-April. Actual enrollment data between January and mid-April suggests that enrollment is occurring faster than previously estimated in November. Additionally, in November the Department assumed all beneficiaries determined eligible would enroll into a managed care plan seamlessly. To date, actual data suggests there is a slight delay prior to being enrolled in a managed care plan.

Methodology:

1. Effective January 1, 2014, the ACA expanded eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the FPL.

2. The Department estimates 1,370,403 newly eligible beneficiaries will enroll in Medi-Cal by June 2014 and grow to 1,647,989 by June 2015. The Department assumes 76.0% of the beneficiaries by June 2014 will be covered by a Medi-Cal managed care plan. By June 2015, the Department assumes managed care enrollment for the newly eligible population will increase to 90.4%.

3. In FY 2013-14, the estimated weighted average per-member-per-month (PMPM) for the newly eligible population is $620.98. The PMPM includes managed care capitation rates, managed care carve-outs, SMH carve-outs, and dental capitated rates. In FY 2013-14, the estimated fee-for-service (FFS) PMPM for the newly eligible population is $243.25 (unlagged). The Department assumes an ongoing 5% inflation factor for PMPM costs.

4. 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.

5. 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).

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

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
Newly Eligible Costs	$2,702,180	$1,769	$2,700,411
Specialty Mental Health carve-outs	$79,284	$0	$79,284
Retroactive Costs	$0	$0	$0
Long Term Support Services (LTSS)	$76,182	$0	$76,182
MCO Tax[1,2]	$0	-$56,913	$0
Total	**$2,857,646**	**-$55,145**	**$2,855,878**

FY 2014-15	**TF**	**GF**	**FF**
Newly Eligible Costs	$11,137,021	$6,283	$11,130,738
Specialty Mental Health carve-outs	$348,384	$0	$348,384
Retroactive Costs	$500,174	$0	$500,174
Long Term Support Services (LTSS)	$568,030	$0	$568,030
MCO Tax[1,2]	$0	-$414,679	$0
Total	**$12,553,610**	**-$408,397**	**$12,547,327**

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 18

Funding:

(Dollars In Thousands)

FY 2013-14:	**TF**	**GF**	**FF**	**SF**
100% Title XIX Federal Share (4260-101-0890)	$2,855,878	$0	$2,855,878	$0
[1]100% GF (4260-101-0001)	($55,144)	($55,144)	$0	$0
[2]MCO Tax Fund (4260-601-3156)	$56,913	$0	$0	$56,913
Total	**$2,857,647**	**($55,144)**	**$2,855,878**	**$56,913**

FY 2014-15:	**TF**	**GF**	**FF**	**SF**
100% Title XIX Federal Share (4260-101-0890)	$12,547,327	$0	$12,547,327	$0
[1]100% GF (4260-101-0001)	($408,396)	($408,396)	$0	$0
[2]MCO Tax Fund (4260-601-3156)	$414,679	$0	$0	$414,679
Total	**$12,553,609**	**($408,396)**	**$12,547,327**	**$414,679**

PAYMENTS TO PRIMARY CARE PHYSICIANS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,691,003,000	$746,248,000
- STATE FUNDS	$29,727,000	$23,500,500
PAYMENT LAG	0.9637	0.9985
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,629,619,600	$745,128,600
STATE FUNDS	$28,647,910	$23,465,250
FEDERAL FUNDS	$1,600,971,680	$721,663,380

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:

- Decrease in fee-for-services (FFS) AB 97 savings lost due to forgiveness of retroactive recoupment for physician providers.
- Updated managed care data to include the impact of Healthy Family transition and managed care expansion to rural counties.
- Some FFS retroactive increase payments will be made in FY 2014-15.

Methodology:

1. Implementation began November 4, 2013, and the increase was 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:

(Dollars in Thousands)

	Annual FFP
FFS	$310,365
Managed Care	$819,171
Total	$1,129,536

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 $49,769,000 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 total General Fund (GF) reimbursement due to the adjustment is $47,266,000.

9. ACA payments for primary care services are exempt from AB 97 (Chapter 3, Statutes of 2011) payment reductions. Due to access concerns, the Department will forgo the retroactive recoupments for Physicians.

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 19

(Dollars in Thousands)

	Annual Savings Lost	Payment Reduction Implementation Date
FFS	$46,152	1/9/2014
Managed Care	$45,350	10/1/2013

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

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
FFS	$206,910	$0	$206,910
FFS Retro	$147,793	$0	$147,793
Managed Care (including Retro)	$1,205,946	$0	$1,205,946
Managed Care GF Reimbursement	$0	($35,450)	$35,450
Total Increase Payment	$1,560,649	($35,450)	$1,596,099
Managed Care Admin. Costs	$73,266	$36,633	$36,633
FFS (AB97 Savings Lost)	$23,076	$11,538	$11,538
Managed Care (AB97 Savings Lost)	$34,012	$17,006	$17,006
Total AB 97 Savings Lost	$57,088	$28,544	$28,544
Total	**$1,691,003**	**$29,727**	**$1,661,276**

FY 2014-15	**TF**	**GF**	**GF**
FFS	$155,183	$0	$155,183
FFS Retro	$110,845	$0	$110,845
Managed Care	$409,585	$0	$409,585
Managed Care GF Reimbursement	$0	($11,817)	$11,817
Total Increase Payment	$675,613	($11,817)	$687,430
Managed Care Admin. Costs	$24,884	$12,442	$12,442
FFS (AB97 Savings Lost)	$23,076	$11,538	$11,538
Managed Care (AB97 Savings Lost)	$22,675	$11,337	$11,337
Total AB 97 Savings Lost	$45,751	$22,875	$22,875
Total	**$746,248**	**$23,500**	**$722,747**

Funding:

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$244,263,000	$228,504,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$244,263,000	$228,504,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$244,263,000	$228,504,000

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:
FYs 2013-14 and 2014-15 estimated figures increased based on data provided by CDSS.

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$419,928,000	$1,993,963,000
- STATE FUNDS	$193,414,050	$929,905,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$419,928,000	$1,993,963,000
STATE FUNDS	$193,414,050	$929,905,350
FEDERAL FUNDS	$226,513,950	$1,064,057,650

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
PC 38 Restoration of Select Adult Dental Benefits

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this 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. Expenditures for Drug Medi-Cal services are not included in this policy change.

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 21

Reason for Change from Prior Estimate:
The Department revised the caseload projections based on enrollment data through mid-April. Actual enrollment data between January and mid-April suggests that enrollment is occurring faster than previously estimated in November. Additionally, in November the Department assumed all beneficiaries determined eligible would enroll into a managed care plan. The Department now assumes a percentage of the population will remain in fee-for-service (FFS).

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 630,798 eligibles will enroll in Medi-Cal by June 2014 and grow to 826,950 by June 2015. 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. The Department assumes 31.3% of the beneficiaries by June 2014 will be covered by a Medi-Cal managed care plan. By June 2015, the Department assumes managed care enrollment for the newly eligible population will increase to 62.2%.

4. In FY 2013-14, it is estimated the weighted average per-member-per-month (PMPM) for those currently eligible but not enrolled is $139.00 except for the TLICP eligibles. The estimated PMPM for TLICP eligible but not enrolled children is $97.10. Both PMPM costs include: managed care capitation rates, managed care carve-outs, and dental capitated rates. In FY 2013-14, the estimated unlagged FFS PMPM for children is $202.95 and $369.41 for adults. The Department assumes an ongoing 5% inflation factor for PMPM costs.

5. 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.

6. 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.

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

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 21

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

(Dollars in Thousands)	FY 2013-14		FY 2014-15	
	TF	GF	TF	GF
Currently Eligible but Uninsured (0-64)				
Adult population (19-64)	$172,653	$86,327	$717,414	$358,707
Percent of Poverty (0-18 years)	$153,101	$76,550	$650,568	$325,284
TLICP (0-18 years)	$65,291	$22,852	$277,487	$97,120
Subtotal (rounded)	$391,044	$185,729	$1,645,469	$781,111
Dental Capitation	$5,127	$2,350	$55,122	$25,267
Retroactive Costs due to CalHEERS delays	$0	$0	$229,750	$108,416
100% of Medicare Primary Care Rates	$13,086	$0	$33,400	$0
Subtotal (rounded)	$18,213	$2,350	$318,271	$133,683
Foster Care Expansion	$10,671	$5,336	$30,223	$15,112
MCO Tax - Benefit to GF	$0	-$383	$0	-$11,792
Net Impact to State (rounded)	**$419,928**	**$193,032**	**$1,993,963**	**$918,114**

Funding:

(Dollars in Thousands)

FY 2013-14	TF	GF/SF	FF
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$340,129	$170,065	$170,065
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$66,713	$23,350	$43,364
100% Title XIX FFP (4260-101-0890)	$13,086	$0	$13,086
3156 MCO Tax (Non-GF) (4260-601-3156)	$0	$383	$0
100% Title XIX GF (4260-101-0001)	$0	($383)	$0
Total	**$419,928**	**$193,414**	**$226,514**

FY 2014-15	TF	GF/SF	FF
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$1,624,722	$812,361	$812,361
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$335,841	$117,544	$218,297
100% Title XIX FFP (4260-101-0890)	$33,400	$0	$33,400
3156 MCO Tax (Non-GF) (4260-601-3156)	$0	$11,792	$0
100% Title XIX GF (4260-101-0001)	$0	($11,792)	$0
Total	**$1,993,963**	**$929,905**	**$1,064,058**

MENTAL HEALTH SERVICES EXPANSION

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$86,512,000	$391,459,000
- STATE FUNDS	$31,682,650	$138,584,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$86,512,000	$391,459,000
STATE FUNDS	$31,682,650	$138,584,950
FEDERAL FUNDS	$54,829,350	$252,874,050

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 has amended 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 extended 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 were used, and costs for the managed care rural expansion and the transition of the Healthy Families Program into managed care were included.

MENTAL HEALTH SERVICES EXPANSION

REGULAR POLICY CHANGE NUMBER: 22

Methodology:
The following chart shows the estimated costs for the mental health services expansion.

(Dollars in Thousands)

FY 2013-14	TF	GF	FF
Managed Care Capitation Rates	$101,299	$40,421	$60,878
Managed Care Drug Costs	$5,371	$1,340	$4,031
FFS Savings	-$20,158	-$10,079	-$10,079
Total	**$86,512**	**$31,682**	**$54,830**
FY 2014-15			
Managed Care Capitation Rates	$413,141	$154,749	$258,392
Managed Care Drug Costs	$21,106	$5,230	$15,876
FFS Savings	-$42,788	-$21,394	-$21,394
Total	**$391,459**	**$138,585**	**$252,874**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
100% Title XIX (4260-101-0890)
65% Title XXI / 35% GF (4260-0001/0290)

ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$33,935,000	$67,870,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$33,935,000	$67,870,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$33,935,000	$67,870,000

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) expands 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 increase in the per-member-per-month (PMPM) costs increased the overall estimated costs. In November, the PMPM was based on inpatient admissions for a blended Medically Needy and Public Assistance family population. In May, the estimated PMPM is based on utilization claims data.

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 utilization claims information, the average cost for an adult inpatient admission is $12,111 for both State and county inmates.

4. The Department estimates the state will process 230 ACA applications per month for state inmates and the counties will process 237 ACA applications for county inmates. All processed applications must have verified citizenship status.

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

FY 2013-14							**TF**	**FF**
State inmates	230	x	6	x	$12,111	=	$16,713,000	$16,713,000
County inmates	237	x	6	x	$12,111	=	$17,222,000	$17,222,000
Total	**467**						**$33,935,000**	**$33,935,000**

FY 2014-15							**TF**	**FF**
State inmates	230	x	12	x	$12,111	=	$33,426,000	$33,426,000
County inmates	237	x	12	x	$12,111	=	$34,444,000	$34,444,000
Total	**467**						**$67,870,000**	**$67,870,000**

Funding:

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

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	4/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1021

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,338,000	$42,017,000
- STATE FUNDS	$2,669,000	$21,008,500
PAYMENT LAG	0.5880	0.9226
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,138,700	$38,764,900
STATE FUNDS	$1,569,370	$19,382,440
FEDERAL FUNDS	$1,569,370	$19,382,440

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 and add-on rates.
- Implementation date for updated add-ons changed from February 1, 2014 to April 1, 2014.
- Projected delay in retroactive payments for rate year 2013-14 from February 1, 2014 to September 1, 2014.

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER: 24

Methodology:

1. Implementation date for AB 1629 add-ons will be April 1, 2014 for the 2013-14 rate year and August 1, 2014 for 2014-15 rate year.

2. Retroactive payments for the 2013-14 rate year is projected to happen in September, 2014.

3. The estimated costs of rate increases are budgeted in the AB 1629 Rate Adjustments Due to QA Fee policy change.

4. The estimated 11-month impact of the August 1, 2013 rate add-ons in FY 2013-14 is already included in the managed care FY 2013-14 capitation rates.

5. 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.

6. 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.

7. 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 and 2014-15 rate years.

8. 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.

9. 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.

10. 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.

11. 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.

12. Effective July 1, 2014, AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour. The current minimum wage is $8.00 per hour. An add-on of $0.30 will be applied to the rate to reimburse facilities for additional cost beginning the 2014-15 rate year.

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER: 24

FFS	FY 2013-14	FY 2014-15
Informed Consent	$625,000	$208,000
Std. Admin Agreement	$96,000	$32,000
FUTA	$1,058,000	$4,232,000
Elder Justice Act	$48,000	$16,000
ACA Reinsurance and PCORI	$192,000	$769,000
ACA Compliance Program	$3,174,000	$12,695,000
HIPAA EFT and E-RADS	$144,000	$577,000
New - Minimum Wage	$0	$5,290,000
FFS Total	$5,338,000	$23,819,000
Managed Care	$0	$3,964,000
Retroactive Add-Ons-FFS	$0	$14,234,000
Total*	**$5,338,000**	**$42,017,000**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$10,390,000	$98,079,000
- STATE FUNDS	$2,202,400	$18,945,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,390,000	$98,079,000
STATE FUNDS	$2,202,400	$18,945,250
FEDERAL FUNDS	$8,187,600	$79,133,750

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:
Effective January 1, 2014, the ACA requires the Department to give hospitals the option 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.

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 25

Reason for Change from Prior Estimate:
The Department revised the caseload projections based on actual enrollment data through February. Actual enrollment in FY 2013-14 for Hospital PE is occurring slower than previously estimated in November. Additionally, actual enrollment reflects a higher percentage of ACA optional expansion beneficiaries than previously assumed in November.

Methodology:

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

2. It is estimated 15,153 average monthly eligibles (between January and June 2014) will receive Hospital PE in FY 2013-14 and 31,574 in FY 2014-15.

3. It is estimated the weighted average per-member-per-month (PMPM) costs are $114.29 (lagged) in FY 2013-14 and $258.85 in FY 2014-15.

4. The Department assumes many of the childless adults and parent/caretaker relatives will continue coverage beyond the presumptive eligibility period and be part of the ACA optional expansion. For those who enter as part of the optional expansion, the Department assumes retroactive ACA enhanced FFP will be available.

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

FY 2013-14	**TF**	**GF**	**FF**
Pregnant Women	$191,000	$95,500	$95,500
Children Title XIX	$984,000	$492,000	$492,000
Children Title XXI	$124,000	$43,000	$81,000
Parents Title XIX	$423,000	$211,500	$211,500
Parents ACA FMAP	$859,000	$0	$859,000
Adults Title XIX	$2,507,000	$1,253,500	$1,253,500
Adults ACA FMAP	$5,089,000	$0	$5,089,000
Former Foster Care	$213,000	$106,500	$106,500
Total	**$10,390,000**	**$2,202,000**	**$8,188,000**

FY 2014-15	**TF**	**GF**	**FF**
Pregnant Women	$1,082,000	$541,000	$541,000
Children Title XIX	$5,576,000	$2,788,000	$2,788,000
Children Title XXI	$705,000	$247,000	$458,000
Parents Title XIX	$2,396,000	$1,198,000	$1,198,000
Parents ACA FMAP	$4,866,000	$0	$4,866,000
Adults Title XIX	$27,144,000	$13,572,000	$13,572,000
Adults ACA FMAP	$55,112,000	$0	$55,112,000
Former Foster Care	$1,198,000	$599,000	$599,000
Total	**$98,079,000**	**$18,945,000**	**$79,134,000**

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 25

Funding:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$4,318	$2,159	$2,159
65% Title XIX / 35% GF (4260-113-0890/0001)	$124	$43	$81
100% Title XIX Federal Share (4260-101-0890)	$5,948	$0	$5,948
Total	**$10,390**	**$2,202**	**$8,188**

FY 2014-15	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$37,396	$18,698	$18,698
65% Title XIX / 35% GF (4260-113-0890/0001)	$705	$247	$458
100% Title XIX Federal Share (4260-101-0890)	$59,978	$0	$59,978
Total	**$98,079**	**$18,945**	**$79,134**

ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

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

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

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Effective January 1, 2014, the Affordable Care Act (ACA) expands 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:
There is no change.

Methodology:

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

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

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

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

(Dollars in Thousands)

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

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

USPSTF GRADE A AND B RECOMMENDATIONS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,926,000	$90,959,000
- STATE FUNDS	$4,377,000	$29,244,000
PAYMENT LAG	0.9805	0.9977
% REFLECTED IN BASE	1.00 %	1.24 %
APPLIED TO BASE		
TOTAL FUNDS	$11,576,500	$89,624,500
STATE FUNDS	$4,248,730	$28,814,950
FEDERAL FUNDS	$7,327,780	$60,809,550

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

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.

The Department received approval of State Plan Amendment (SPA 13-014) to receive the additional 1% in FMAP, requiring 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 added alcohol misuse screening and counseling services in primary care settings to the existing benefit package for beneficiaries 18 years and older.

Reason for Change from Prior Estimate:
Managed care costs increase due to updated ACA caseload.

Methodology:
1. This new service was implemented on 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 receive 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. Fee-for-Service (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 201-15. The PMPM costs include screening and intervention costs.

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

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

FY 2013-14	**TF**	**GF**	**FFP**
Managed Care			
ACA Optional Expansion	$3,172,000	$0	$3,172,000
ACA Mandatory Expansion & Medi-Cal Age 18-64	$7,992,000	$3,996,000	$3,996,000
Managed Care Total	$11,164,000	$3,996,000	$7,168,000
FFS			
Screening Costs	$466,000	$233,000	$233,000
Intervention Costs	$296,000	$148,000	$148,000
FFS Total	$762,000	$381,000	$381,000
Total	**$11,926,000**	**$4,377,000**	**$7,549,000**

FY 2014-15	**TF**	**GF**	**FFP**
Managed Care			
ACA Optional Expansion	$32,471,000	$0	$32,471,000
ACA Mandatory Expansion & Medi-Cal Age 18-64	$48,554,000	$24,277,000	$24,277,000
Managed Care Total	$81,025,000	$24,277,000	$56,748,000
FFS			
Screening Costs	$6,072,000	$3,036,000	$3,036,000
Intervention Costs	$3,862,000	$1,931,000	$1,931,000
FFS Total	$9,934,000	$4,967,000	$4,967,000
Total	**$90,959,000**	**$29,244,000**	**$61,715,000**

USPSTF GRADE A AND B RECOMMENDATIONS

REGULAR POLICY CHANGE NUMBER: 27

Funding:
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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$150,904,000	$53,303,000
- STATE FUNDS	$70,579,550	$26,011,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$150,904,000	$53,303,000
STATE FUNDS	$70,579,550	$26,011,700
FEDERAL FUNDS	$80,324,450	$27,291,300

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 and several Non-MAGI groups. This delay only impacts those beneficiaries scheduled to receive a redetermination between January 1, 2014 and June 30, 2014.

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA expanded 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.

Effective January 1, 2014, the Department will postpone redeterminations for 6-months for Medi-Cal beneficiaries who will be subject to the new MAGI standard and several non-MAGI groups. This 6-month delay provides counties with additional time to process the new incoming ACA expansion beneficiaries.

Reason for Change from Prior Estimate:
In November, the policy change assumed a 3-month delay and now assumes a 6-month delay. Additionally, the delayed renewals expanded to include select Non-MAGI (Medically Needy and Long Term Care) populations.

ACA DELAY OF REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER: 28

Methodology:

1. Effective January 1, 2014, the Department will delay redeterminations until July 1, 2014 for current Medi-Cal beneficiaries. The Department assumes all delayed redeterminations will be complete no later than December 31, 2014.

2. The Department estimates Medi-Cal enrollment during the 6-month period will increase by 150,586 additional member months for the MAGI population and 719,640 for the Non-MAGI population.

3. The average PMPM during this period for the MAGI population is $198.10, and $242.31 for the Non-MAGI population.

4. Total estimated (unlagged) costs related to the delay in redeterminations is:
   - MAGI: 150,586 additional member months x $198.10 PMPM = $29,831,000 TF (unlagged)
   - Non-MAGI: 719,640 member months x $242.31 PMPM = $174,376,000 TF (unlagged)
   - Total: $29,831,000 + $174,376,000 = **$204,207,000 TF** (unlagged)

5. Because of the weighted fee-for-service (FFS) 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:
   - FY 2013-14: $204,207,000 TF x .7390 weighted FFS payment lag = **$150,904,000** TF
   - FY 2014-15: $204,207,000 - $150,904,000 = **$53,303,000** TF

Funding:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$139,654	$69,826	$69,827
65% Title XXI FFP / 35% GF (4260-113-0890/0001)	$693	$243	$450
100% Title XIX ACA FFP (4260-113-0890)	$10,047	$0	$10,047
100% GF (4260-101-0001)	$510	$510	$0
Total	**$150,904**	**$70,579**	**$80,324**

FY 2014-15	**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$51,496	$25,748	$25,748
65% Title XXI FFP / 35% GF (4260-113-0890/0001)	$102	$36	$66
100% Title XIX ACA FFP (4260-113-0890)	$1,477	$0	$1,477
100% GF (4260-101-0001)	$228	$228	$0
Total	**$53,303**	**$26,012**	**$27,291**

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	6/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1802

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$115,000	$115,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$115,000	$115,000
FEDERAL FUNDS	-$115,000	-$115,000

DESCRIPTION

Purpose:
This policy change estimates a technical adjustment in funding from Title XIX 50/50 FMAP to 100% State GF for expenditures related to extending Medi-Cal coverage to former foster care youth who turned 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 changed 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 who turned 21 years old between July 1, 2013 and December 31, 2013 retained their Medi-Cal benefits. These costs are funded with 100% State General Fund.

Reason for Change from Prior Estimate:
In November, this policy change estimated benefits costs for the former foster youth who retained coverage. This policy change now assumes actual benefits costs are captured in base trends, and estimates a technical adjustment to repay CMS for the ineligible FFP.

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

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER: 29

2. The Department estimates 549 former foster youth turned 21 years old between July 1, 2013 and December 31, 2013.

3. The total expenditures incurred during the July and December 2013 time frame are expected to be paid over a 12-month period. The Department assumes half of the FFP repayment will occur in FY 2013-14 and the remaining in FY 2014-15.

	FY 2013-14	FY 2014-15
Total Expenditures	$230,000	$230,000
FFP Repayment	**$115,000**	**$115,000**

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

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	-$45,932,000	-$39,582,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$45,932,000	-$39,582,000
FEDERAL FUNDS	$45,932,000	$39,582,000

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:
PC 27 USPSTF Grade A and B Recommendations

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 updated ACA caseload.

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

2. Implementation for this program began on January 1, 2014.

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 30

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

(Dollars In Thousands)

FY 2013-14	**TF**	**GF**	**FFP**
FFS	$0	($2,508)	$2,508
Managed Care	$0	($13,810)	$13,810
Retroactive Savings	$0	($29,614)	$29,614
Total	**$0**	**($45,932)**	**$45,932**

FY 2014-15	**TF**	**GF**	**FFP**
FFS	$0	($5,099)	$5,099
Managed Care	$0	($34,483)	$34,483
Total	**$0**	**($39,582)**	**$39,582**

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

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	4/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1742

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$5,000	-$94,000
- STATE FUNDS	-$2,500	-$47,000
PAYMENT LAG	0.4120	0.8150
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,100	-$76,600
STATE FUNDS	-$1,030	-$38,300
FEDERAL FUNDS	-$1,030	-$38,300

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 change is due to a delay in implementation.

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 31

Methodology:

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

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

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

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

	TF	GF	FF
FY 2013-14	**($5,000)**	**($3,000)**	**($2,000)**
FY 2014-15	**($94,000)**	**($47,000)**	**($47,000)**

Funding:

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

MANAGED CARE DRUG REBATES

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$379,500,000	-$330,400,000
- STATE FUNDS	-$189,750,000	-$165,200,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$379,500,000	-$330,400,000
STATE FUNDS	-$189,750,000	-$165,200,000
FEDERAL FUNDS	-$189,750,000	-$165,200,000

DESCRIPTION

Purpose:
This policy change estimates the amount of monies received from the collection of 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, HR 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 and FY 2013-14. $156,500,000 in MCO rebates were included in the Aged and Disputed Drug Rebate Policy Change (PC-59). The rebates included in this PC are only those paid or expected to be paid within 90 days of the postmark date of the invoice.

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 $320,000,000.

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 $91,500,000 will be collected from the retroactive rebates (2010Q1 – 2013Q1)

FY 2013-14		
$320,000,000 x 90%	=	$288,000,000
$288,000,000 + $91,500,000	=	**$379,500,000**

4. For FY 2014-15, assume the there is a 5% increase to the annual collection rate due to the expansion of managed care into rural areas, and overall collection rate will continue to be 90% of invoiced amounts beginning in FY 2014-15, and $28,000,000 will be collected from the retroactive rebates (2010Q1 – 2013Q1)

FY 2014-15		
($320,000,000 x 105%) x 90%	=	$302,400,000
$302,400,000 + $28,000,000	=	**$330,400,000**

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

(Dollars in Thousands)	
Managed Care Drug Rebates FY 2013-14	
Retroactive Collections (2010Q1 – 2013Q1)	$ 91,500
To be Collected from FY 2013-2014	$ 288,000
Total FY 2013-14	**$ 379,500**
Managed Care Drug Rebates FY 2014-15	
Retroactive Collections (2010Q1 – 2013Q1)	$ 28,000
To be Collected from FY 2013-2014	$ 302,400
Total FY 2014-15	**$ 330,400**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$182,932,000	$312,967,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$182,932,000	$312,967,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$182,932,000	$312,967,000

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. However, under CMS guidance, it was determined an amendment to the 1915(i) SPA was not necessary, and the Department will instead seek to amend an existing

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 35

interagency agreement with the California Department of Developmental Services to draw down FFP for infant development services.

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 2013-14.

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

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

(Dollars in Thousands)

	Total Funds	CDDS GF	FFP	ARRA
FY 2013-14	$365,864	$182,932	**$182,932**	**$0**
FY 2014-15	$620,562	$307,595	**$310,281**	**$2,686**

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$144,983,000	$144,536,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$144,983,000	$144,536,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$144,983,000	$144,536,000

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:
There is no material change.

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 will make the final cost settlement of $3,560,876 to LEAs in FY 2013-14.

5. The estimated reconciliation for FY 2008-09 $4,000,000 will be applied to FY 2014-15.

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

(Dollars In Thousands)	TF	FF
FY 2013-14 Interim Payments	$141,423	$141,423
FY 2007-08 Reconciliation	$3,560	$3,560
FY 2013-14 Total	**$144,983**	**$144,983**
FY 2014-15 Interim Payments	$140,536	$140,536
FY 2008-09 Reconciliation	$4,000	$4,000
FY 2014-15 Total	**$144,536**	**$144,536**

Funding:

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$45,621,000	$26,085,000
- STATE FUNDS	$1,478,000	$2,819,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,621,000	$26,085,000
STATE FUNDS	$1,478,000	$2,819,000
FEDERAL FUNDS	$44,143,000	$23,266,000

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 365-days, 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 550 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:
Costs decreased based on updated actual and projected CCT enrollment.

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	($14,073)	($7,037)	($20,218)	($10,109)
Lagged costs	**$16,657**	**$1,478**	**$26,085**	**$2,819**
CDDS prior year costs	**$28,964**	**$0**	**$0**	**$0**
Net	$31,548	($5,558)	$5,867	($7,290)

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$9,121,000	$311,879,000
- STATE FUNDS	$3,173,000	$109,948,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,121,000	$311,879,000
STATE FUNDS	$3,173,000	$109,948,000
FEDERAL FUNDS	$5,948,000	$201,931,000

DESCRIPTION

Purpose:
This policy change estimates the benefit costs to restore select 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). Additionally, effective September 26, 2014, per the United States Court of Appeals for the Ninth Circuit in the case of California Association of Rural Health Clinics, et al., v. Toby Douglas, Director of the California Department of Health Care Services, et al., Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs), may also provide services pursuant to the scope of covered adult dental benefits available on June 30, 2009.

AB 82 restores partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services that can be offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including FQHCs and RHCs, will be limited to the adult optional benefits being restored May 1, 2014, in addition to the current scope of adult dental benefits which include services for pregnant women, emergency services, FRADs, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers.

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 restored adult dental benefit cost for the ACA expansions is included in this

RESTORATION OF SELECT ADULT DENTAL BENEFITS

REGULAR POLICY CHANGE NUMBER: 38

policy change. 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.

State Plan Amendment (SPA) 13-018 which makes the necessary changes to the State Plan to reflect the restoration of select adult dental benefits was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 30, 2013.

Reason for Change from Prior Estimate:
Methodology now incorporates latest adult eligible caseload projections and data, including ACA optional and mandatory expansions.

Methodology:

1. Assume the implementation date is May 2014.

2. The services being restored had an estimated cost in FY 2010-11 of $118,308,000.

3. Based upon the estimated increase in adult eligibles, the current annual cost of restoring these benefits is estimated to be $356,968,000.

4. Assume that there will be a six-month phase-in before costs reach their ongoing level.

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

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
Current/Mandatory Eligibles (50/50)	$6,346	$3,173	$3,173
ACA Optional Expansion (100% FFP)	$2,775	$0	$2,775
Total Costs	**$9,121**	**$3,173**	**$5,948**
FY 2014-15			
Current/Mandatory Eligibles (50/50)	$219,896	$109,948	$109,948
ACA Optional Expansion (100% FFP)	$91,983	$0	$91,983
Total Costs	**$311,879**	**$109,948**	**$201,931**

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

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

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

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "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 12,000 participants in 9,443 participant slots, at $4,285 per year per 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. No sooner than 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

As CCI is implemented, MSSP will transition to being a Medi-Cal managed care benefit in all CCI demonstration counties (Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, San Bernardino, and Riverside). The total MSSP reimbursement (both for fee-for-service (FFS) and managed care (MC)) is budgeted in this policy change.

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

Methodology:

(Dollars in Thousands)

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

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

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	4/2013
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1775

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$34,320,000	$34,170,000
- STATE FUNDS	$17,160,000	$17,085,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$34,320,000	$34,170,000
STATE FUNDS	$17,160,000	$17,085,000
FEDERAL FUNDS	$17,160,000	$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 organized health care delivery models to serve the CCS Medi-Cal eligible population.

Effective April 1, 2013, the Health Plan of San Mateo (HPSM) an existing managed care organization, began operation as a demonstration project under the Department's 1115 Bridge to Reform Waiver model.

Reason for Change from Prior Estimate:
The average monthly enrollment estimate for FY 2013-14 has been revised.

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 40

Methodology:

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

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

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

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

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

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

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

6. Assume the CCS Pilot program is budget neutral.

(Dollars in Thousands)

	TF	HPSM	COHS	CCS Case Management
FY 2013-14	$0	**$34,020**	($31,584)	($2,436)
FY 2014-15	$0	**$34,020**	($31,584)	($2,436)

7. The Department has a contract with UCLA for the evaluation of the CCS Program Pilot. The negotiated contract costs are stated in the following table.

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

(Dollars in Thousands)

FY 2013-14	**TF**	**FFP**	**GF**
HPSM	$34,020	$17,010	$17,010
UCLA-IE	$300	$150	$150
Total	**$34,320**	**$17,160**	**$17,160**

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

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 40

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

YOUTH REGIONAL TREATMENT CENTERS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,910,000	$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	$3,910,000	$6,345,000
STATE FUNDS	$776,000	$34,000
FEDERAL FUNDS	$3,134,000	$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) for YRTC services provided to eligible American Indian Medi-Cal members under the age of 21.

Reason for Change from Prior Estimate:
The implementation delay from the prior estimate resulted in lower than expected enrollment in FY 2013-14.

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

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 41

2. Details of the estimated expenditures:
   a. The number of youths in FY 2013-14: 10
   b. The estimated annual number of youths in FY 2014-15: 50
   c. The average stay per youth: 180 days
   d. The estimated daily rate per youth: Calendar Year 2013 rate is $660
   e. The estimated daily rate is estimated to increase annually by $30.

FY 2013-14
(2013 calendar year rate of $660)
10 youths x 122 days per youth x $660 per day = $805,200 TF from September 2013 through December 2013, or $201,300 TF per month.

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

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

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

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

Amounts may differ due to rounding.

FY 2013-14	**TF**	**GF**	**FFP**
Sept. 2013-Dec. 2013	$805,000	$402,000	$403,000
*Sept. 2013-Dec. 2013	$0	($402,000)	$403,000
Jan. 2014-June 2014	$3,105,000	$776,000	$2,329,000
Total FY 2013-14	**$3,910,000**	**$776,000**	**$3,314,000**
FY 2014-15			
*Apr.-June 2014	$0	($776,000)	$776,000
July 2014-Dec 2014	$3,105,000		$3,105,000
**Jan. 2015-June 2015	$3,240,000	$810,000	$2,430,000
Total FY 2014-15	**$6,345,000**	**$34,000**	**$6,311,000**

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

Funding:
50% Title XIX FFP / 50% GF (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:	Joel Singh
FISCAL REFERENCE NUMBER:	1754

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,631,000	$4,841,000
- STATE FUNDS	$2,315,500	$2,420,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	95.85 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$192,200	$0
STATE FUNDS	$96,090	$0
FEDERAL FUNDS	$96,090	$0

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 age 40 years 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 change from prior estimate.

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

2. Assume mammography exams include screening and diagnostic.

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.

DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING

REGULAR POLICY CHANGE NUMBER: 42

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 (FFS).

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

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

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

Funding:
50% GF / 50% Title XIX (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,477,000	$3,912,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,477,000	$3,912,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,477,000	$3,912,000

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:
Updated actual and projected CCT enrollment adjusted FY 2013-14 and FY 2014-15 costs.

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-DD 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	$1,401,000	$1,616,000
CDDS	$1,076,000	$2,296,000
Total	**$2,477,000**	**$3,912,000**

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

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	7/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1787

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

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Effective July 1, 2013, the Department reimbursed PPCW agencies for administrative costs. This policy change provides $300 per member per month to reimburse the PPCW agencies for indirect services, such as administrative support, overhead, and program training.

Reason for Change:
There is no change.

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

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

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

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 44

3. This program is effective July 1, 2013.

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

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

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$226,000	$516,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$226,000	$516,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$226,000	$516,000

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 increased due to updated actual enrollment.

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 revised to 30 individuals and 54 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 257, and 516 in FY 2014-15.

3. Due to a four-month payment lag, 36 participant months from FY 2012-13, along with 149 participant months from FY 2013-14 will be paid in FY 2013-14. The remaining 108 participant months will be paid in FY 2014-15, along with 312 participant months for FY 2014-15.

4. The annual total cost is estimated to be $28,644 per participant in FY 2012-13 and $29,475 per participant in FYs 2013-14 and 2014-15.

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

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

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

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$139,000	$150,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$139,000	$150,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$139,000	$150,000

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 increased due to actual data from FYs 2011-12 and 2012-13. CCT participation is projected to increase in FY 2014-15 based on data from prior years.

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, 442 beneficiaries were transitioned in the CCT demonstration project and 452 additional beneficiaries transitioned into CCT in FY 2012-13. Projected enrollments are 500 in FY 2013-14 and 550 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
452 x $100 = $45,200 First follow up
442 x $100 = $44,200 Second follow up

FY 2013-14 Estimated Costs: **$139,000 TF**

550 x $100 = $55,000 Baseline
500 x $100 = $50,000 First follow up
452 x $100 = $45,200 Second follow up

FY 2014-15 Estimated Costs: **$150,000 TF** (rounded)

Funding:

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

SCHIP FUNDING FOR PRENATAL CARE

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$89,107,200	-$92,502,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$89,107,200	-$92,502,800
FEDERAL FUNDS	$89,107,200	$92,502,800

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $130,593,000 in FY 2013-14 and $135,817,000 in FY 2014-15.

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

(Rounded)		
FY 2013-14:	$130,593,000 x .65 =	$84,885,000 FFP
FY 2014-15:	$135,817,000 x .65 =	$88,281,000 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 $6,495,000 for FY 2013-14 and $6,495,000 for FY 2014-15.

(Rounded)		
FY 2013-14:	$6,495,000 x .65 SCHIP FFP =	$4,222,000 FFP
FY 2014-15:	$6,495,000 x .65 SCHIP FFP =	$4,222,000 FFP

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

FY 2013-14 Savings:	$84,885,000 + $4,222,000 =	**$89,107,000**
FY 2014-15 Savings:	$88,281,000 + $4,222,000 =	**$92,503,000**

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

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

DESCRIPTION

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

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

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:
There is no change from prior estimate.

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 (4260-101-0890/0001)

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	11/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1770

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$3,260,000	-$21,430,000
- STATE FUNDS	-$3,039,400	-$4,554,900
PAYMENT LAG	0.6865	0.9634
% REFLECTED IN BASE	35.40 %	16.91 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,445,700	-$17,154,500
STATE FUNDS	-$1,347,910	-$3,646,150
FEDERAL FUNDS	-$97,830	-$13,508,330

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.

The expansion of access to long-acting reversible contraceptives (LARCs) gives women greater choice in selecting a contraceptive that meets their needs to delay, space, or limit pregnancy. Of all the family planning methods, results show LARCs with the highest continuation rate. LARCs prove 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 and Medi-Cal Fee-for-Service, effective November 1, 2013, the Department plans to:

- Decrease the onsite dispensing of emergency contraception under Family PACT from two packs per dispensing to one pack per dispensing,
- Add onsite dispensing of the emergency contraceptive, ella®,
- Eliminate urine culture,
- Discontinue brand name anti-fungal drugs,
- Increase the dispensing fee for LARCs, and
- Increase reimbursement rates for pregnancy termination services under Medi-Cal by 40%.

Effective January 1, 2014, the Department plans to:

- Eliminate mammograms, and
- Eliminate pregnancy test-only benefit.

Effective April 1, 2014, the Department plans to reduce chlamydia screening of women over 25 years of age.

Effective July 1, 2014, the Department plans to adopt a Medi-Cal Preferred List for oral contraceptives.

Reason for Change from Prior Estimate:
Changes in the estimate were due to delayed implementation and claims were based on more current data.

Methodology:
1. The estimated savings below is based on FY 2012-13 data:

Benefit	FMAP*	FY 2013-14 TF	FY 2014-15 TF
Chlamydia Screening	90%	($4,308,000)	($17,233,000)
Emergency Contraception	90%	($2,531,000)	($10,231,000)
Clinical dispensing of ella®	90%	$1,139,000	$1,752,000
Medi-Cal List of Oral Contraceptives	90%	$0	($4,000,000)
Mammograms	0%	($2,649,000)	($4,628,000)
Urine Culture	50%	($244,000)	($361,000)
Brand Name Antifungal Drug	50%	($491,000)	($792,000)
Pregnancy Test Only	90%	($192,000)	($311,000)
LARC Fee Increase	90%	$6,016,000	$8,874,000
Abortion Rate Increase	0%	$0	$5,500,000
Total Savings		**($3,260,000)**	**($21,430,000)**

*FMAP: Federal Medical Assistance Percentage

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

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 51

FY 2013-14	TF	GF	FFP
90/10 Savings	$106,000	$10,000	$96,000
50/50 Savings	($632,000)	($316,000)	($316,000)
100% GF Savings	($2,734,000)	($2,734,000)	$0

FY 2014-15	TF	GF	FFP
90/10 Savings	($18,199,000)	($1,820,000)	($16,379,000)
50/50 Savings	($992,000)	($496,000)	($496,000)
100% GF Savings	($2,239,000)	($2,239,000)	$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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$14,073,000	-$20,218,000
- STATE FUNDS	-$7,036,500	-$10,109,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$14,073,000	-$20,218,000
STATE FUNDS	-$7,036,500	-$10,109,000
FEDERAL FUNDS	-$7,036,500	-$10,109,000

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 365 days, 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 550 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 based on actual data resulting in increased 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	**($14,073)**	**($7,037)**	**($20,218)**	**($10,109)**
Lagged costs	$16,657	$1,478	$26,085	$2,819
CDDS prior year costs	$28,964	$0	$0	$0
Net	$31,548	($5,558)	$5,867	($7,290)

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,815,000	$28,892,000
- STATE FUNDS	$2,407,500	$14,446,000
PAYMENT LAG	0.7026	0.9915
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,383,000	$28,646,400
STATE FUNDS	$1,691,510	$14,323,210
FEDERAL FUNDS	$1,691,510	$14,323,210

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 by a special liquid food formula that bypasses the upper digestive tract. AB 97 (Chapter 3, Statutes of 2011) limited enteral nutrition products (formula) 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:
Payment lag has been updated.

Methodology:
1. The restoration of enteral nutrition products administered orally for adults will be implemented May 1, 2014 with utilization controls through the establishment of specific medical criteria.

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 for oral-fed adults are estimated to be:

   $32,777,000
   -$ 3,885,000
   $28,892,000 ($14,446,000 GF)

5. The restoration of coverage for oral-fed adults is assumed to begin May 1, 2014, so there are two months of CY impact:

   $28,892,000 x (2/12 months) = $4,815,333

6. There is a FY 2013-14 payment lag of 0.7026 and a FY 2014-15 payment lag of 0.9915.

   $4,815,333 x 0.7026 = $3,383,000
   $28,892,000 x 0.9915 = $28,646,418

7. Total expenditures for adults:

(Dollars in Thousands)

	TF	GF	FF
Total FY 2013-14	**$ 3,383**	**$ 1,692**	**$ 1,692**
Total FY 2014-15	**$ 28,646**	**$ 14,323**	**$14,323**

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

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	3/2007
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	108

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$2,044,500	$2,106,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$2,044,500	$2,106,000
FEDERAL FUNDS	-$2,044,500	-$2,106,000

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 April 2013 to September 2013.

Methodology:
1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased. Based on data from July 2004 to September 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)

	Non-FFP Drug Expenditures	Est. FFP Repayment
FY 2013-14	$ 4,089	**$ 2,045**
FY 2014-15	$ 4,212	**$ 2,106**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$15,389,000	-$15,764,000
- STATE FUNDS	-$5,386,150	-$5,517,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$15,389,000	-$15,764,000
STATE FUNDS	-$5,386,150	-$5,517,400
FEDERAL FUNDS	-$10,002,850	-$10,246,600

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14105.33(b)(4)

Interdependent Policy Changes:
Not Applicable

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

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

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.

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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	10/2006
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1181

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$24,428,000	-$24,428,000
- STATE FUNDS	-$12,214,000	-$12,214,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$24,428,000	-$24,428,000
STATE FUNDS	-$12,214,000	-$12,214,000
FEDERAL FUNDS	-$12,214,000	-$12,214,000

DESCRIPTION

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

Authority:
Welfare & 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. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

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:
Based on data available at the time of the November Estimate, the Department anticipated a drop in the total amount of rebates collected due to population shifts from FFS to managed care and changes in utilization controls. However, analysis of more current data shows that rebate collections have not been impacted as initially predicted due to the rebate percentage increase resulting from the renegotiated contracts.

Methodology:
1. The current medical supply diabetic testing products rebate contract terms were effective January 1, 2013.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 56

2. Based on actual rebate data for the last four quarters, the average quarterly collection is $6,107,000.

3. Based on the current contract terms, assume no significant change in rebate collected.

FY 2012-13:
$6,107,000 x 4 qtrs. = **$ 24,428,000**

FY 2013-14:
$6,107,000 x 4 qtrs. = **$ 24,428,000**

CASH BASIS	Medical Supply Rebates
Est. FY 2013-14	**($ 24,428,000)**
Est. FY 2014-15	**($ 24,428,000)**

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	12/1999
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	51

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$78,108,000	-$73,085,000
- STATE FUNDS	-$10,000,800	-$9,357,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$78,108,000	-$73,085,000
STATE FUNDS	-$10,000,800	-$9,357,700
FEDERAL FUNDS	-$68,107,200	-$63,727,300

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 August 2013 to December 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 December 2013 to project rebates.

CASH BASIS
(Dollars in Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2012-13	$142,146	($71,914)
Est. FY 2013-14	$150,530	**($78,108)**
Est. FY 2014-15	$144,463	**($73,085)**

	TF	GF	FF
FY 2013-14	**($78,108)**	($10,001)	($68,107)
FY 2014-15	**($73,085)**	($9,358)	($63,727)

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

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	8/2009
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1449

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$88,253,000	$0
- STATE FUNDS	-$88,253,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$88,253,000	$0
STATE FUNDS	-$88,253,000	$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:

	FY 2013-14
Amgen 2	($648,000)
Bioscrip	($65,000)
Bioscrip	($279,000)
Bioscrip	($371,000)
Bio Med	($2,000,000)
CareFusion	($784,000)
Dava Pharmaceuticals, Inc	($72,000)
Endo Pharmaceuticals	($420,000)
Genzyme	($104,000)
ISTA Pharmaceuticals	($169,000)
Johnson and Johnson	($2,977,000)
Johnson & Johnson (Janssen)	($42,700,000)
Johnson & Johnson (Omnicare)	($1,848,000)
Kmart Corp.	($29,000)
KV Pharmaceuticals, Inc.	($59,000)
Medtronic	($17,000)
Novatris	($4,000)
Omnicare	($163,000)
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)
Saint Helen's	($160,000)
Victory Pharma	($1,000)
Total GF Savings, Initial Settlement Amts	($88,253,000)

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$286,000,000	-$196,000,000
- STATE FUNDS	-$142,973,600	-$97,982,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$286,000,000	-$196,000,000
STATE FUNDS	-$142,973,600	-$97,982,000
FEDERAL FUNDS	-$143,026,400	-$98,018,000

DESCRIPTION

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

Authority:
Welfare & Institutions Code, Section 14105.33

Interdependent Policy Changes:
PC 60 State Supplemental Drug Rebates
PC 61 Federal Drug Rebate Program
PC 55 BCCTP Drug Rebates
PC 57 Family PACT Drug Rebates
PC 211 MCO Supplemental Drug Rebates

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.

MCO Rebates
The aged and disputed rebates associated with the MCOs will be included in this PC but identified separately for tracking purposes.

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59

Reason for Change from Prior Estimate:
MCO drug rebates are now included in this policy change.

With the final expansion of managed care to the balance of the state in late 2013, there was a corresponding decrease in the FFS utilization and a reduction in the amount of rebates associated with the non-MCO aged and disputed category. Also, the transition of both the Healthy Families and Low Income Health Program populations, the Department expects the MCO Aged and Disputed category to be higher in 2014-15. The Department expects these amounts to decrease beginning in late 2014 into FY 2015-16 as MCOs become more familiar with the data reporting requirements and the drug manufacturers complete their internal system adjustments.

Methodology:

1. For MCO related Aged and Disputed Rebates, it is estimated that the Department will collect $156,000,000 in FY 2013-14 and $66,000,000 in FY 2014-15.

2. For non-MCO Aged and Disputed Rebates, it is estimated that the Department will collect $130,000,000 in FY 2013-14 and $130,000,000 in FY 2014-15.

3. The family planning drug portion accounts for 0.023% of the rebates. This is funded at 90% FFP and 10% GF.

	TF	GF	FF
FY 2013-14 (50/50 FFP)	$ 285,933,991	$ 142,966,996	$ 142,966,996
FY 2013-14 (10/90 FFP)	$ 66,009	$ 6,601	$ 59,408
	$ 286,000,000	**$ 142,973,597**	**$ 143,026,404**

	TF	GF	FF
FY 2014-15 (50/50 FFP)	$ 195,954,763	$ 97,977,382	$ 97,977,382
FY 2014-15 (10/90 FFP)	$ 45,237	$ 4,524	$ 40,713
	$ 196,000,000	**$ 97,981,906**	**$ 98,018,095**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$209,567,000	-$161,296,000
- STATE FUNDS	-$102,848,700	-$79,158,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$209,567,000	-$161,296,000
STATE FUNDS	-$102,848,700	-$79,158,800
FEDERAL FUNDS	-$106,718,300	-$82,137,200

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 July 2013 to December 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 2.308% 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	($204,730,000)	($102,365,000)	($157,573,000)	($78,787,000)
Title XIX 10/90	($4,837,000)	($484,000)	($3,723,000)	($372,000)
Total	**($209,567,000)**	**($102,849,000)**	**($161,296,000)**	**($79,159,000)**

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

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	7/1990
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	55

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,378,767,000	-$1,299,000,000
- STATE FUNDS	-$599,064,200	-$559,917,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,378,767,000	-$1,299,000,000
STATE FUNDS	-$599,064,200	-$559,917,100
FEDERAL FUNDS	-$779,702,800	-$739,082,900

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 July 2013 to December 2013. In addition, the ongoing additional federal financial participation (FFP) claimed by Centers for Medicare and Medicaid Services (CMS) increased.

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

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5. Family planning drugs account for 2.308% of rebates and are funded with 90% federal funds and 10% General Fund.

6. Beginning July 2012, the ongoing additional FFP of $155,181,000, claimed by CMS, is fully reflected in this policy change.

	FY 2013-14		
	TF	**GF**	**FFP**
50% Title XIX / 50% GF	($1,191,764,000)	($595,882,000)	($595,882,000)
90% Title XIX / 10% GF	($31,822,000)	($3,182,000)	($28,640,000)
100% Title XIX FFP	($155,181,000)	$0	($155,181,000)
Total	**($1,378,767,000)**	**($599,064,000)**	**($779,703,000)**

	FY 2014-15		
	TF	**GF**	**FFP**
50% Title XIX / 50% GF	($1,113,838,000)	($556,919,000)	($556,919,000)
90% Title XIX / 10% GF	($29,981,000)	($2,998,000)	($26,983,000)
100% Title XIX FFP	($155,181,000)	$0	($155,181,000)
Total	**($1,299,000,000)**	**($559,917,000)**	**($739,083,000)**

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

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1811

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$10,179,000	$28,925,000
- STATE FUNDS	$4,092,500	$10,622,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	12.22 %	6.39 %
APPLIED TO BASE		
TOTAL FUNDS	$8,935,100	$27,076,700
STATE FUNDS	$3,592,400	$9,943,720
FEDERAL FUNDS	$5,342,730	$17,132,970

DESCRIPTION

Purpose:
This policy change estimates the reimbursement funds for the Voluntary Inpatient Detoxification service.

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

Interdependent Policy Changes:
Not Applicable

Background:
Voluntary Inpatient Detoxification is an inpatient hospital service included in the State Plan. This service is provided when determined medically necessary, and with the voluntary participation of the Medi-Cal beneficiary.

Welfare & Institutions Code, Section 14132.03 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 the package includes additional services that are currently not covered, Medi-Cal extended coverage for this new Voluntary Inpatient Detoxification service, effective January 1, 2014.

This change affects existing Medi-Cal beneficiaries as well as the newly eligibles that are added as a result of the Affordable Care Act (ACA) mandatory and optional expansions. For existing Medi-Cal beneficiaries and ACA mandatory expansion eligibles, reimbursement will be 50% FFP and 50% GF. For ACA optional expansion eligibles, reimbursement will be 100% FFP.

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

Methodology:
1. The eligible caseload projections are based on the average monthly eligibles projected for the

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 66

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 122 for FY 2013-14 (January – June 2014) and 629 for FY 2014-15.

4. Assume the caseload projection for the optional expansion population is 357 for FY 2013-14 (January – June 2014) and 1,255 for FY 2014-15.

5. Assume the Units of Service (UOS) is five days of service per patient.

6. The proposed rate for Voluntary Inpatient Detoxification services is $1,490 per day based on the 2012 average Medi-Cal Selective Provider Contracting Program rate.

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

FY 2013-14	Caseload	UOS	Rate	Total
Regular	1,343	5	$ 1,490	$ 10,005,350
Mandatory	122	5	$ 1,490	$ 906,920
Optional	357	5	$ 1,490	$ 2,659,323
				$ 13,571,593

FY 2014-15	Caseload	UOS	Rate	Total
Regular	2,685	5	$ 1,490	$ 20,003,250
Mandatory	629	5	$ 1,490	$ 4,686,413
Optional	1255	5	$ 1,490	$ 9,353,054
				$ 34,042,716

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

Fiscal Year	Accrual	FY 2013-14	FY 2014-15
FY 2013-14	$13,572,000	$10,179,000	$3,393,000
FY 2014-15	$34,043,000	$0	$25,532,000
		$10,179,000	$28,925,000

9. The estimate on a cash basis will be:

(Dollars In Thousands)

Cash Basis

	TF	GF	FF
FY 2013-14	**$ 10,179**	**$ 4,092**	**$ 6,087**
FY 2014-15	**$ 28,925**	**$ 10,623**	**$ 18,302**

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 66

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,036,000	$3,036,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,036,000	$3,036,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,036,000	$3,036,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for cost settlements to counties and contracted providers for payments related to 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:
There is no change.

Methodology:

1. The interim cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.

2. Final cost settlements are based on comparing actual expenditures against audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.

3. Costs are estimated to total $3,429,000 for FY 2013-14 and FY 2014-15. In the FY 2011-12, the General Funds (GF) were replaced by County Funds (CF).

FY 2011-12

Settlements	**TF**	**CF**	**FFP**
Regular (Item 103)	$3,206,000	$398,000	$2,808,000
Perinatal (Item 102)	$223,000	($5,000)	$228,000
Total for FY 2013-14	$3,429,000	$393,000	**$3,036,000**

FY 2012-13

Settlements	**TF**	**CF**	**FFP**
Regular (Item 103)	$3,206,000	$398,000	$2,808,000
Perinatal (Item 102)	$223,000	($5,000)	$228,000
Total for FY 2014-15	$3,429,000	$393,000	**$3,036,000**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$2,607,000
- STATE FUNDS	$0	-$248,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$2,607,000
STATE FUNDS	$0	-$248,000
FEDERAL FUNDS	$0	-$2,359,000

DESCRIPTION

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6 (b)(1); 14021.9 (c); and 14105 (a)
Title 22, California Code of Regulations, Section 51516.1 (a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates for use in FY 2013-14 or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- Narcotic Treatment Program (NTP) – Dosing
- NTP - Individual Counseling
- NTP - Group Counseling
- Intensive Outpatient Treatment, previously Day Care Rehabilitative
- Naltrexone Treatment Service
- Residential Treatment, previously Perinatal Residential
- Outpatient Drug Free (ODF) - Individual Counseling
- ODF- Group Counseling

For FY 2014-15, the DMC reimbursement rate was adjusted to eliminate the 10% county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. The county administration costs will be paid under a quarterly invoicing process. The county administration costs

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 68

can be found in the policy change titled DMC County Admin.

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

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

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2. The incremental difference between FY 2013-14 required rates and FY 2014-15 required rates are:

Regular-Services		FY 2013-14 Required Rates		FY 2014-15 Required Rates		Incremental Difference
NTP-Dosing		$11.49		$10.80		($0.69)
NTP-Individual		$14.46		$13.48		($0.98)
NTP- Group		$3.27		$2.91		($0.36)
Intensive Outpatient		$62.15		$56.44		($5.71)
Naltrexone		$19.07		$19.06		($0.01)
ODF-Individual		$72.32		$67.38		($4.94)
ODF-Group		$29.39		$26.23		($3.16)

Perinatal-Services		FY 2013-14 Required Rates		FY 2014-15 Required Rates		Incremental Difference
NTP-Dosing		$12.57		$11.79		($0.78)
NTP-Individual		$20.70		$21.06		$0.36
NTP- Group		$6.91		$7.03		$0.12
Intensive Outpatient		$79.39		$80.78		$1.39
Residential Treatment		$97.72		$99.43		$1.71
ODF-Individual		$103.52		$105.32		$1.80
ODF-Group		$62.24		$63.33		$1.09

3. The cost estimate is developed by the following:

   Caseload x Units of Service (UOS) x Rates

4. The incremental rate change on an accrual basis is shown below:

Regular (Program 20)	
Narcotic Treatment	($7,168,060)
Intensive Outpatient	($7,508,261)
Outpatient Drug Free	($8,219,089)
Residential Treatment	$2,611,561
Total for Regular	($20,283,849)
Perinatal (Program 25)	
Narcotic Treatment	($4,278)
Intensive Outpatient	$58,091
Outpatient Drug Free	$14,926
Perinatal	$81,676
Total for Perinatal	$150,416

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

	Accrual	FY 2013-14	FY 2014-15
Regular	($20,283,849)	($15,212,887)	($5,070,962)
Perinatal	$150,416	$112,812	$37,604
Total	($20,133,433)	($15,100,075)	($5,033,358)

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 68

6. The annual rate adjustment for FY 2014-15 is:

	Total	GF	FFP	County Funds*
FY 2013-14	($15,100,075)	($744,368)	($7,077,628)	($7,278,079)
FY 2014-15	($5,033,358)	**($248,123)**	**($2,359,209)**	($2,426,027)

*****County funds are not budgeted.

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

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	6/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1458

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$64,187,000	$353,018,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$64,187,000	$353,018,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$64,187,000	$353,018,000

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 State Plan Amendment and Certified Public Expenditure Protocol are pending approval from the Centers for Medicare and Medicaid Services (CMS).

Reason for Change from Prior Estimate:
Supplemental payments for FYs 2009-10 and 2010-11 are moved to FY 2014-15 because the related cost reports will not be settled until early in FY 2014-15.

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)

	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2008-09 FFP	$52,103	$12,079	$64,187
Total for FY 2013-14	$52,103	$12,079	**$64,187**
FY 2009-10 FFP	$90,402	$20,484	$110,886
FY 2010-11 FFP	$95,008	$22,532	$117,540
FY 2011-12 FFP	$124,592	$0	$124,540
Total for FY 2014-15	$310,002	$43,016	**$353,018**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$67,962,000	$72,161,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$67,962,000	$72,161,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$67,962,000	$72,161,000

DESCRIPTION

Purpose:
This policy change estimates the elimination of the state maximum rates for Medi-Cal specialty mental health services (SMHS).

Authority
AB 1297 (Chapter 651, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The Welfare and Institution (W&I) Code, sections 5720 and 5724, limited reimbursement of SMHS to the state maximum rates. The state maximum rate is a schedule of maximum allowances (SMA) for SMHS. 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. The elimination of the state maximum rate was implemented in the Short-Doyle/Medi-Cal (SD/MC) claiming system in fiscal year 2012-13.

Reason for Change from Prior Estimate:
The change is due to a change in methodology. The November estimate was based on cost report data. This estimate is based on FY 2012-13 claims data and actual claiming patterns.

Methodology:

1. The costs are developed using FY 2012-13 approved claims from each county.

2. The approved units, by county and type of services, were multiplied by the SMA rate that would

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 72

have been in place in FY 2012-13 to calculate the SMA limit.

3. The SMA limit calculated in step 2 above was subtracted from the approved amount by county and service type to calculate the approved amount in excess of the SMA for FY 2012-13.

4. The FY 2013-14 children's SMHS estimate was increased by 6.09% and the estimate for adult SMHS was increased by 4.18% which is the increase in the accrual estimated for SD/MC services in the SMHS for Children policy change and the SMHS for Adults policy change.

5. The FY 2014-15 children's SMHS estimate was increased by 5.47% and the estimate for adult SMHS was increased by 4.01% which is the increase in the accrual estimated for SD/MC services in the SMHS for Children policy change and the SMHS for Adults policy change.

6. The accrual estimates are:

(Dollars In Thousands)

FY 2012-13	TF	FFP	County
Children	$83,214	$41,607	$41,607
Adults	$49,612	$24,806	$24,806
Total	$132,826	$66,413	$66,413

(Dollars In Thousands)

FY 2013-14	TF	FFP	County
Children	$88,282	$44,141	$44,141
Adults	$51,686	$25,843	$25,843
Total	$139,968	$69,984	$69,984

(Dollars In Thousands)

FY 2014-15	TF	FFP	County
Children	$93,349	$46,675	$46,674
Adults	$53,758	$26,879	$26,879
Total	$147,107	$73,554	$73,553

7. On a cash basis for FY 2013-14, the Department will be paying 38% of FY 2012-13 claims and 62% of FY 2013-14 claims. In FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 37% of FY 2013-14 claims and 62% of FY 2014-15 claims.

(Dollars In Thousands)

FY 2012-13	TF	FFP	County
Children	$31,621	$15,811	$15,811
Adults	$18,853	$9,426	$9,426
Total	$50,474	$25,237	$25,237

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 72

(Dollars In Thousands)

FY 2013-14	TF	FFP	County
Children	$54,735	$27,368	$27,367
Adults	$32,045	$16,022	$16,023
Total	$86,780	$43,390	$43,390
Total FY 2013-14	$137,254	**$68,627**	$68,627

(Dollars In Thousands)

FY 2012-13	TF	FFP	County
Children	$832	$416	$416
Adults	$496	$248	$248
Total	$1,328	$664	$664

(Dollars In Thousands)

FY 2013-14	TF	FFP	County
Children	$32,664	$16,332	$16,332
Adults	$19,124	$9,562	$9,562
Total	$51,788	$25,894	$25,894

(Dollars In Thousands)

FY 2014-15	TF	FFP	County
Children	$57,876	$28,938	$28,938
Adults	$33,330	$16,665	$16,665
Total	$91,206	$45,603	$45,603
Total FY 2014-15	$144,323	**$72,161**	$72,161

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

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1719

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$29,886,000	$41,848,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$29,886,000	$41,848,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$29,886,000	$41,848,000

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:
Pursuant to AB 1494, HFP subscribers were transitioned into the Medi-Cal program using a phased-in approach that began January 2013 and concluded November 2013. Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) enrollees were 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 that transitioned from the HFP to Medi-Cal 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 federal funds participation (FFP) through the Certified Public Expenditure (CPE) process.

HFP subscribers that transitioned into 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.

Reason for Change from Prior Estimate:
Expenditures have been revised based on the updates to HFP claim lag.

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 73

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 shifted 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 Medi-Cal specialty mental health services.

4. Additional psychiatric inpatient services will be provided by the mental health plans that were previously covered by the HFP managed care plans.

(In Thousands)

	TF	FFP	County
SED Services	$24,604	$15,993	$8,611
Outpatient	$34,646	**$22,520**	$12,126
Inpatient	$11,332	**$7,366**	$3,966
FY 2013-14	$70,582	$45,879	$24,703

(In Thousands)

	TF	FFP	County
SED Services	$35,310	$22,952	$12,358
Outpatient	$48,514	**$31,534**	$16,980
Inpatient	$15,868	**$10,314**	$5,554
FY 2014-15	$99,692	$64,800	$34,892

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$29,293,000	$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	$29,293,000	$26,751,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$29,293,000	$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. The Department plans to submit a State Plan Amendment by March 31, 2014 to the CMS to implement TFC services. If federally approved as a Medi-Cal service, TFC services will be available by August 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 ÷ 12 months x 6 months = $26,751,000

6. Based on historical claims received, assume 62% of the each fiscal year claims will be paid in the year the services occur. The remaining 38% is paid in the following year. Due to startup billing delays for FY 2012-13 services, assume 95% of the claims are paid in FY 2013-14.

(In Thousands)

Cash Estimate	TF	FFP	County
FY 2012-13	$25,414	$12,707	$12,707
FY 2013-14	$33,172	$16,586	$16,586
FY 2013-14	$58,586	**$29,293**	$29,293
FY 2013-14	$20,330	$10,165	$10,165
FY 2014-15	$33,172	$16,586	$16,586
FY 2014-15	$53,502	**$26,751**	$26,751

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$18,769,000	$7,070,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,769,000	$7,070,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$18,769,000	$7,070,000

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% federal funds participation (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 December 31, 2012, HFP stopped enrolling new subscribers and the current HFP subscribers began transitioning into the Medi-Cal program in phases. The last group of HFP children transitioned to Medi-Cal on November 1, 2013.

Reason for Change from Prior Estimate:
The accrual estimate is zeroed in FY 2014-15 since all HFP children were transitioned by November 2013. Other revisions are a result of updated HFP claim lag.

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 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	$0	$0	$0

6. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 37% of FY 2012-13 claims, and 62% 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	$10,821	$7,034	$3,787
FY 2013-14	$17,738	$11,530	$6,208
TOTAL FY 2013-14	$28,875	**$18,769**	$10,106

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, 37% of FY 2013-14 claims, and 62% of FY 2014-15 claims for SD/MC claims.

(Dollars In Thousands)

Cash Estimate	TF	FFP	County
FY 2012-13	$292	$190	$102
FY 2013-14	$10,585	$6,880	$3,705
FY 2014-15	$0	$0	$0
TOTAL FY 2014-15	$10,877	**$7,070**	$3,807

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$12,400,000	$24,800,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,400,000	$24,800,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$12,400,000	$24,800,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for mobile crisis support teams and triage personnel to enhance mental health services for community wellness.

Authority:
SB 82 (Chapter 34, Statutes of 2013) Investment in Mental Health Wellness Act of 2013

Interdependent Policy Changes:
Not Applicable

Background:
The Investment in Mental Health Wellness Act of 2013 specifies to add 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds over the next two years to expand community-based resources and capacity. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders. The California Health Facilities Financing Authority (CHFFA) 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 will began in 2014, depending on approved grant applications. Applications were submitted in January 2014 and are currently under review by CHFFA for funding.

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 (MHSOAC) 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 initial triage personnel grants were awarded to 22 counties in January 2014.

INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER: 76

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

Methodology:
1. The federal portion is shown below:

(Dollars In Thousands)

	FY 2013-14	FY 2014-15
Mobile Crisis Teams	$1,400	$2,800
600 Triage Personnel	$11,000	$22,000
Total	**$12,400**	**$24,800**

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

OVER ONE-YEAR CLAIMS

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1717

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,353,000	$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	$3,353,000	$3,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,353,000	$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:
Changes are due to additional claims information.

Methodology:
1. One-year claims are based on actual claims received from the counties.

(In Thousands)

	TF	FFP	County
FY 2013-14	$6,705	**$3,353**	$3,352
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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$2,270,000	$0
- 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	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,270,000	$0

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 related Medi-Cal specialty mental health claims expenditures will be included in base policies for FY 2014-15.

Methodology:
1. Partnership Health Plan has identified that it pays out approximately $4.5 million TF to Solano County Mental Health Plan in annual capitation payments for SMHS.

(In Thousands)

	TF	FFP	County
FY 2013-14	$4,540	**$2,270**	$2,270

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:
There is no change.

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.

3. Siskiyou County will reimburse the GF $200,000 annually. As a result, of the total FFP repayment of

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 79

$7,204,000 that the Department will make in FY 2013-14, $7,004,000 will be paid from the GF. Reimbursements are shown in the Management Summary.

Date of Overpayment Discovery	FY 2013-14 Repayment		FY 2014-15 Repayment	
8/4/2011	$2,090,000			
11/15/2011	$ 586,000			
12/21/2011	$ 95,000			
3/26/2012	$443,000			
1/30/2013	$2,859,000			
5/30/2013	$1,131,000			
Total:	**$7,204,000**	GF		
	($200,000)		**($200,000)**	Reimbursement

Funding:
GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

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

DESCRIPTION

Purpose:
This policy change estimates the cost of federal financial participation (FFP) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs). This policy change also includes the general fund (GF) reimbursement for inappropriately claimed Medi-Cal ancillary services provided to beneficiaries in IMDs.

Authority:
Title 42, Code of Federal Regulations 435.1009
Welfare & Institutions Code 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 repaid to CMS.

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 80

This policy change budgets the costs for the Department to repay the FFP portion of IMD costs to the CMS and the total reimbursement to be collected from the counties to repay the Department and CMS. This policy change now incorporates policy change Reimbursement in IMD Ancillary Services Costs, which budgets the total reimbursement to be collected from the counties to repay the Department and CMS.

Reason for Change from Prior Estimate:
The reimbursement in the policy change titled Reimbursement in IMD Ancillary Services Cost is now incorporated in this policy change.

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

2. In FY 2013-14, the Department expects to collect costs beginning FY 2008-09. These costs will be determined using the inappropriately paid claims for IMD ancillary services and charged to the county responsible for the beneficiary as indicated in MEDS.

3. The GF reimbursement includes repayment for both FFP and any state funds paid for the ancillary services provided to residents of IMDs.

(In Thousands)

Dates of Service	FY 2013-14	FY 2014-15
FY 2008-09	($12,000)	$0
FY 2009-10	$0	$(12,000)
Total	**($12,000)**	**($12,000)**

4. The GF & FFP repayment to CMS for FY 2013-14 and FY 2014-15 is:

(Dollars in Thousands)

Services Received	FY 2013-14	FY 2014-15
10/01/10 - 09/30/11	$12,000	$0
10/01/11 - 09/30/12	$0	$12,000
Total	**$12,000**	**$12,000**

Funding:
100% General Fund (4260-101-0001)
Title XIX FFP (4260-101-0890)
Reimbursement (4260-610-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1714

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$1,271,000	-$320,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,271,000	-$320,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,271,000	-$320,000

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:
There is a backlog of recoupments from prior years that decreased the estimate for both fiscal 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.

	TF	FFP
FY 2013-14	**($1,271,000)**	**($1,271,000)**
FY 2014-15	**($320,000)**	**($320,000)**

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1713

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$41,760,000	$0
- STATE FUNDS	$27,777,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$41,760,000	$0
STATE FUNDS	$27,777,000	$0
FEDERAL FUNDS	-$69,537,000	$0

DESCRIPTION

Purpose:
This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:
Welfare & Institution Code 14705(c)
Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim settlements to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlement is completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83

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

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.

	Underpaid	Overpaid	Net
Interim Settlement (FY 2008-09)			
Children and Adults	$0	($24,540)	($24,540)
M-CHIP*	$69	($1,419)	($1,350)
Healthy Families*	$1,307	($2,353)	($1,046)
Interim Settlement (FY 2009-10)			
Children and Adults	$56,470	($76,075)	($19,605)
M-CHIP*	$2,983	($2,052)	$931
Healthy Families*	$89	($3,886)	($3,797)
Interim Settlement (FY 2010-11)			
Children and Adults	$51,645	($73,696)	($22,051)
M-CHIP*	$802	($2,646)	($1,844)
Healthy Families*	$1,051	($1,952)	($901)
Final Settlement (Multi-Years)			
Children and Adults	$46,576	($42,259)	$4,317
M-CHIP*	$959	($219)	$740
Healthy Families*	$1,436	($1,827)	($391)
Total FY 2013-14	$163,387	($232,924)	($69,537)

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.

4. Cost settlements prior to 2011 Realignment may consist of general fund (GF) and federal financial participation (FFP).

(Dollars In Thousands)

	TF	GF	FFP
Children and Adults	($34,102)	$27,777	($61,879)
M-CHIP*	($1,523)	$0	($1,523)
Healthy Families*	($6,135)	$0	($6,135)
Total FY 2013-14	$20,685	**$27,777**	**($69,537)**

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 83

Funding:
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)*
100% General Fund (4260-101-0001)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2011
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1578

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,039,826,000	$4,210,969,000
- STATE FUNDS	$127,029,500	$1,985,006,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,039,826,000	$4,210,969,000
STATE FUNDS	$127,029,500	$1,985,006,000
FEDERAL FUNDS	$912,796,500	$2,225,963,000

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 was effective November 1, 2010, through December 31, 2013, under the BTR and consisted of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE covered eligible individuals with family incomes at or below 133% of Federal Poverty Level. The HCCI covered 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:
For November 2013 estimate, LIHP had projected all CPE (payments and reconciliations), IGT-CAP and IGT-FQHC payments to be completed in FY 2013-14. Due to delays with claim processing, CPE reconciliations and all IGT CAP payments will be made in FY 2014-15. Overall projection is 4% less than prior estimate and is due to updated enrollment information.

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, FY 2012-13 and FY 2013-14 payments to the new capitated rates will occur in FY 2014-15.

3. 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. All payments are expected to be made in FY 2013-14.

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 84

The estimated MCE payments on a cash basis are:

(Dollars in Thousands)

FY 2013-14	TF	IGT CAP	IGT-FQHC	FFP	CPE*
2011-12 (CPEs)	$36,288			$36,288	$36,288
2011-12 (IGT-FQHC)	$83,917		$41,958	$41,958	
2012-13 (CPEs)	$368,410			$368,410	$368,410
2012-13 (IGT-FQHC)	$127,911		$63,956	$63,956	
2013-14 (CPEs)	$381,069			$381,069	$381,069
2013-14 (IGT-FQHC)	$42,230		$21,115	$21,115	
Total**	**$1,039,826**	**$0**	**$127,029**	**$912,796**	$785,767

FY 2014-15	TF	IGT CAP	IGT-FQHC	FFP	CPE*
2010-11 (CPEs)	$160,614			$160,614	$160,614
2011-12 (CPEs)	$27,304			$27,304	$27,304
2011-12 (IGT CAP)	$990,986	$495,493		$495,493	
2012-13 (CPEs)	$35,672			$35,672	$35,672
2012-13 (IGT CAP)	$1,857,308	$928,654		$928,654	
2013-14 (CPEs)	$17,368			$17,368	$17,368
2013-14 (IGT CAP)	$1,121,717	$560,859		$560,859	
Total**	**$4,210,969**	**$1,985,006**	**$0**	**$2,225,963**	$240,957

Funding:
LIHP IGT Fund (4260-607-8502)
100% Title XIX (4260-101-0890)

*Not included in TF.
**Amounts may differ due to rounding.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1073

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,655,852,000	$1,762,250,000
- STATE FUNDS	$396,202,000	$592,433,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,655,852,000	$1,762,250,000
STATE FUNDS	$396,202,000	$592,433,000
FEDERAL FUNDS	$1,259,650,000	$1,169,817,000

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)
AB 1066 (Chapter 86, Statutes of 2011)
House Joint Resolution 59 (2013)

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. Non-emergency services for undocumented individuals are eligible for DSH program funding. The 2013-14 and 2014-15 DSH allotments are estimated to be $1,169,118,239.

- 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.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 85

- 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. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.
- Private DSH hospitals, under the Special Terms and Conditions and SPA 05-22, are allocated a total of $160.00 from the federal DSH allotment and State General Fund (GF) each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

The DSH allotment temporarily increased for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the American Recovery and Reinvestment Act of 2009 (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.

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 2013-14 and FY 2014-15.

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.

AB 1066 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.

The Affordable Care Act (ACA) reduction in the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, House Joint Resolution 59, passed by Congress and signed by the President on December 26, 2013, delays the reduction until October 1, 2015. The reductions for each state will be determined by CMS.

Reason for Change from Prior Estimate:
The overall increases are due to increases in the DSH allotments and estimated IGTs. In addition, DSH payments to NDPHs were updated to be paid in FY 2013-14 and FY 2014-15.

Methodology:
It is assumed that the DSH payments will be made as follows on a cash basis:

(Dollars In Thousands)

FY 2013-14	**TF**	**GF****	**FF**	**IGT***
DSH 2010-11	$1,834	$917	$917	$0
DSH 2011-12	($2,799)	$847	$94,325	($97,971)
DSH 2012-13	$42,870	$615	$92,800	($50,545)
DSH 2013-14	$1,613,947	$11,833	$1,071,608	$530,506
	$1,655,852	**$14,212**	**$1,259,650**	**$381,990**

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 85

FY 2014-15	TF	GF**	FF	IGT*
DSH 2012-13	$1,230	$615	$615	$0
DSH 2013-14	$146,905	$1,167	$97,510	$48,228
DSH 2014-15	$1,614,115	$11,917	$1,071,692	$530,506
	$1,762,250	**$13,699**	**$1,169,817**	**$578,734**

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

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	3/2011
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1570

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,474,435,000	$1,152,624,000
- STATE FUNDS	$737,217,500	$576,312,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,474,435,000	$1,152,624,000
STATE FUNDS	$737,217,500	$576,312,000
FEDERAL FUNDS	$737,217,500	$576,312,000

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 five categories 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
(5) HIV Transition Projects

Category 5 payments are budgeted in the BTR—LIHP—DSRIP HIV Transition Projects policy change. 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.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 86

The total federal funding for DSRIP for categories 1-4 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:

(Dollars in Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	$ 1,006,880	$ 591,601
2011-12	$ 1,300,000	$ 650,000
2012-13	$ 1,400,000	$ 700,000
2013-14	$ 1,400,000	$ 700,000
2014-15	$ 1,400,000	$ 700,000

Reason for Change from Prior Estimate:
The decrease is due to the implementation of carry forward limitations for DY 2011-12 and DY 2012-13 and 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. For categories 1 and 2, hospitals that did not achieve full funding for DY 2010-11 through 2012-13 can claim the remaining funding until the end of the waiver, subject to the following carry forward limitations:
   - Carry forward funding from DY 2010-11 and DY 2011-12 is subject to a 10% penalty beginning January 1, 2014.
   - Carry forward funding from DY 2012-13 is subject to a 10% penalty beginning July 1, 2014.
   - The Special Terms and Conditions (STCs) of the BTR waiver do not allow funding to be carried forward in categories 1 and 2 for DY 2013-14 and DY 2014-15.
   - In DY 2010-11, DPHs claimed 100% of DSRIP funding in categories 1 and 2 so there are no carry forward funds associated with these years.

3. For categories 1 and 2, DPHs have 90 days from January 1, 2014 to claim the available carry forward funds for DY 2010-11 and DY 2011-12, and 90 days from July 1, 2014 to claim carry forward funds for DY 2012-13. Assume the DPHs will claim all of the available carry forward amounts.

4. The STCs do not allow carry forward funding associated with category 3.

5. The STCs allow DPHs to carry forward funding associated with category 4 through the end of the BTR waiver.

6. DPH payments on a cash basis for FY 2013-14 and FY 2014-15 include DSRIP claiming for DY 2013-14 and 2014-15 as well as carry forward claiming.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 86

7. It is anticipated that hospitals will achieve 55% of the DY 2013-14 funding in the March 2014 payment and 95% of the remaining amount available by the September 2014 payment.

8. DY 2014-15 spans FY 2014-15 and FY 2015-16, and covers a total of 16 months. The Department assumes 6 months of DY 2014-15 will be claimed in FY 2014-15.

9. The STCs require the Department to report any unused DSRIP amounts eligible to be rolled over into the Safety Net Care Pool (SNCP) to CMS by January 1, 2015. The Department will request that these amounts be rolled to the SNCP to cover other safety net services.

10. On a cash basis, DSRIP payments are estimated to be:

(Dollars in Thousands)

		TF	IGT	FF
FY 2013-14				
	DY 2011-12	$5,072	$2,536	$2,536
	DY 2012-13	$699,363	$349,682	$349,681
	DY 2013-14	$770,000	$385,000	$385,000
		$1,474,435	**$737,218**	**$737,217**
FY 2014-15				
	DY 2012-13	$13,374	$6,687	$6,687
	DY 2013-14	$614,250	$307,125	$307,125
	DY 2014-15	$525,000	$262,500	$262,500
		$1,152,624	**$576,312**	**$576,312**

Funding:
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1071

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$608,376,000	$551,013,000
- STATE FUNDS	$304,188,000	$275,506,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$608,376,000	$551,013,000
STATE FUNDS	$304,188,000	$275,506,500
FEDERAL FUNDS	$304,188,000	$275,506,500

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)
House Joint Resolution 59 (2013)

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.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 87

The Affordable Care Act (ACA) reduction to the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, House Joint Resolution 59, passed by Congress and signed by the President on December 26, 2013, delays the reduction until October 1, 2015. 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.

Reason for Change from Prior Estimate:
The change is due to increases in the DSH allotments. Payments for 2009-10, 2010-11, 2011-12, and 2012-13 have been updated to be paid in FY 2013-14 and FY 2014-15.

Methodology:

1. The remaining balance of 2009-10, 2010-11, 2011-12, and 2012-13 final payments are assumed to be paid in FY 2013-14 and FY 2014-15.

2. SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by $10.5 million TF ($5.25 million GF) in 2013-14.

3. 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.

4. 11 months of 2014-15 payments are assumed to be paid in FY 2014-15.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2013-14	**TF**	**GF**	**FF**
2009-10	$1,489,000	$744,500	$744,500
2010-11	$51,935,000	$25,967,500	$25,967,500
2011-12	$30,577,000	$15,288,500	$15,288,500
2012-13	$40,000,000	$20,000,000	$20,000,000
2013-14	$494,000,000	$247,000,000	$247,000,000
SB 335	($9,625,000)	($4,812,500)	($4,812,500)
Net	$484,375,000	$242,187,500	$242,187,500
Total FY 2013-14	**$608,376,000**	**$304,188,000**	**$304,188,000**

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 87

FY 2014-15	TF	GF	FF
2009-10	$989,000	$494,500	$494,500
2010-11	$1,415,000	$707,500	$707,500
2011-12	$1,696,000	$848,000	$848,000
2012-13	$11,451,000	$5,725,500	$5,725,500
2013-14	$44,695,000	$22,347,500	$22,347,500
SB 335	($875,000)	($437,500)	($437,500)
Net	$43,820,000	$21,910,000	$21,910,000
2014-15	$491,642,000	$245,821,000	$245,821,000
Total FY 2014-15	**$551,013,000**	**$275,506,500**	**$275,506,500**

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

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	11/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1573

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$317,250,000	$242,250,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$317,250,000	$242,250,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$317,250,000	$242,250,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) for uncompensated care provided to individuals with no source of third party coverage for the services they receive.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.71
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after November 1, 2010 until October 31, 2015, based on the Special Terms and Conditions of the BTR, a new SNCP was established to support the provision of services to the uninsured. The SNCP is to be claimed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in Demonstration Year (DY) 6 of the BTR demonstration. This policy change estimates the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

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

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 88

Methodology:

1. Interim payments are made in four payments to the DPHs on a quarterly basis. The fourth quarter payment is split into two payments. Payments are made in October, January, April, June, and July. The June payment includes the months of April and May, while the July payment is for the month of June.

2. The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands) Demonstration Year	State-Only Funded Programs	Due to DPHs
2010-11 (DY 6)	$400,000	$565,422
2011-12 (DY 7)	$400,000	$436,000
2012-13 (DY 8)	$400,000	$386,000
2013-14 (DY 9)	$400,000	$311,000
2014-15 (DY 10)	$400,000	$236,000

3. Assume 11/12 of the DPH payments for a DY are made during the same fiscal year and the remaining 1/12 is paid in the subsequent fiscal year.

4. The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands) Demonstration Year	FY 2013-14 FF	FY 2014-15 FF
2012-13	$32,167	
2013-14	$285,083	$25,917
2014-15		$216,333
Total	**$317,250**	**$242,250**

Funding:

100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	89
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1085

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$250,602,000	$268,001,000
- STATE FUNDS	$125,301,000	$134,000,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$250,602,000	$268,001,000
STATE FUNDS	$125,301,000	$134,000,500
FEDERAL FUNDS	$125,301,000	$134,000,500

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
State Plan Amendment 13-002

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, 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).

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 89

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 the requirements specified in SB 1100.

Reason for Change from Prior Estimate:
The changes are due to updated IGTs and program expenditures. The increased IGT payments in FY 2013-14 and FY 2014-15 are due to new hospital eligibility.

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 $8,000,000 in FY 2013-14 and $31,000,000 in FY 2014-15.
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:

	TF	SF	FF
FY 2013-14			
FY 2012-13 Ending Balance	$104,982,000	$52,491,000	$52,491,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Redirect Stabilization Fund to GF	($36,080,000)	($18,040,000)	($18,040,000)
Redirect ARRA to GF	($46,000,000)	($23,000,000)	($23,000,000)
Net Appropriation	$154,720,000	$77,360,000	$77,360,000
Est. FY 2012-13 interest	$400,000	$200,000	$200,000
IGT	$8,000,000	$4,000,000	$4,000,000
Total	$268,102,000	$134,051,000	$134,051,000
Cash Expenditures to Hospitals	**$250,602,000**	**$125,301,000**	**$125,301,000**
SB 335 Reduction	$17,500,000	$8,750,000	$8,750,000
FY 2013-14 Ending Balance	$0	$0	$0
FY 2014-15			
FY 2013-14 Ending Balance	$0	$0	$0
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2013-14 interest	$201,000	$100,500	$100,500
IGT	$31,000,000	$15,500,000	$15,500,000
Total	$268,001,000	$134,000,500	$134,000,500
Cash Expenditures to Hospitals	**$268,001,000**	**$134,000,500**	**$134,000,500**
FY 2014-15 Ending Balance	$0	$0	$0

Funding:
100% GF (4260-105-0001)
Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
50% Title XIX / 50% Private Hospital Supplemental Fund (4260-601-3097/4260-101-0890)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	11/2010
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1572

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$134,376,000	$21,373,000
- STATE FUNDS	$23,076,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$134,376,000	$21,373,000
STATE FUNDS	$23,076,000	$0
FEDERAL FUNDS	$111,300,000	$21,373,000

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, consisted of two components, the Medicaid Coverage Expansion (MCE) and the HCCI (CI). The MCE covered eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those eligible individuals with family incomes above 133% through 200% of the FPL. Both were 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:

- Updated payments data were lower than projected.
- CPE reconciliation payments for DY 6 through DY 9 have been delayed and will now be paid in FY 2014-15.
- Reallocation of unused HCCI funds for DY 9 has been shifted from FY 2013-14 to FY 2014-15.

Methodology:

1. All CPE and IGT-FQHC payments for DY 7 through DY 9 will be paid in FY 2013-14.

2. All CPE reconciliation payments for DY 6 through DY 9 will be paid in FY 2014-15.

3. Reallocation of unused HCCI funds for DY 8 and DY 9 will be made in FY 2013-14 and FY 2014-15.

4. The estimated HCCI payments on a cash basis are:

FY 2013-14	TF	IGT-FQHC	FFP
DY7 - FY 2011-12	$27,167,000	$9,848,000	$17,319,000
DY8 - FY 2012-13	$37,101,000	$10,191,000	$26,910,000
DY8 - FY 2012-13 (Rollover)	$48,500,000		$48,500,000
DY9 - FY 2013-14	$21,608,000	$3,037,000	$18,571,000
Total*	**$134,376,000**	**$23,076,000**	**$111,300,000**

FY 2014-15	TF	IGT-FQHC	FFP
DY6 - FY 2010-11	$369,000		$369,000
DY7 - FY 2011-12	$4,571,000		$4,571,000
DY8 - FY 2012-13	$2,641,000		$2,641,000
DY9 - FY 2013-14	$793,000		$793,000
DY9 - FY 2013-14 (Rollover)	$13,000,000		$13,000,000
Total*	**$21,373,000**	**$0**	**$21,373,000**

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 90

Funding:
Health Care Support Fund (4260-601-7503)
Title XIX FFP (4260-101-0890)
LIHP IGT (4260-607-8502)

*Amounts may differ due to rounding.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1108

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$134,565,000	$117,158,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$134,565,000	$117,158,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$134,565,000	$117,158,000

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 increased 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 claimed 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 $13.089 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 $4.318 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.

The estimated CCS/GHPP federal reimbursements are:

(Dollars in Thousands)	CCS	GHPP	Total
FY 2005-06	$15,523	$8,485	$24,008
FY 2006-07	$46,856	$15,300	$62,156
FY 2007-08	$18,000	$8,000	$26,000
FY 2008-09	$20,958	$21,336	$42,294
FY 2009-10	$114,023	$41,073	$155,096
FY 2010-11	$59,959	$25,613	$85,572
FY 2011-12	$102,046	$55,019	$157,065
FY 2012-13	$67,718	$34,811	$102,529

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 91

(Dollars in Thousands)			
FY 2013-14	**CCS FF**	**GHPP FF**	**Total**
DSHP-BTR (DY 2013-14)	$77,038	$44,438	$121,476
DY 2010-11 Final Reconciliation	($2,010)	$15,099	$13,089
Total	**$75,028**	**$59,537**	**$134,565**
FY 2014-15			
DSHP-BTR (DY 2014-15)	$77,038	$44,438	$121,476
DY 2011-12 Final Reconciliation	($7,707)	$3,389	($4,318)
Total	**$69,331**	**$47,827**	**$117,158**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$110,000,000	$0
- STATE FUNDS	$55,000,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$110,000,000	$0
STATE FUNDS	$55,000,000	$0
FEDERAL FUNDS	$55,000,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Delivery System Reform Incentive Pool (DSRIP) Category 5 Human Immunodeficiency Virus (HIV) Transition Projects. Non-federal share of the payments are made through intergovernmental transfers (IGTs).

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

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 92

LIHP enrollees diagnosed with HIV, particularly those enrollees who previously received services under 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 established 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.

The DSRIP Category 5 HIV Transition Projects were effective from July 1, 2012 through December 31, 2013. DPHs that implemented these approved projects receive incentive payments under the Safety Net Care Pool (SNCP) upon achievement of project milestones. According to the carry forward provisions of the STC, Attachment P – Supplement 1, the DPHs have until the end of the demonstration, October 31, 2015, to achieve the project milestones.

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) was 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 DPHs on the basis of its approved proposal. Payment amounts will be disbursed in semi-annual payments, if project milestones are achieved.

(Dollars in Thousands)

FY 2013-14	**TF**	**IGT**	**FFP**
FY 2012-13	$55,000	$27,500	$27,500
FY 2013-14	$55,000	$27,500	$27,500
Total	**$110,000**	**$55,000**	**$55,000**

Funding:
DSRIP IGT Fund (4260-601-3172)
Title XIX FFP (4260-101-0890)

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER:	93
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1622

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$19,933,000	$275,629,000
- STATE FUNDS	$12,095,000	$135,686,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,933,000	$275,629,000
STATE FUNDS	$12,095,000	$135,686,000
FEDERAL FUNDS	$7,838,000	$139,943,000

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:
Updated data identified the availability of HQARF 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 QAF collections and disbursements project that $98 million is available for transfer from the HQARF funds for FY 2011-12, FY 2012-13 and FY 2013-14.

4. LIHPs will provide utilization data for FY 2011-12, FY 2012-13, and FY 2013-14 to the Department after the fiscal year. The LIHP ended on December 31, 2013. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations.

5. The LIHP funds will be used to reimburse out-of-network hospitals.

6. IGTs will be deposited into and paid from the LIHP MCE Out-of-Network Emergency Care Services Fund.

(Dollars in Thousands)

FY 2013-14	**TF**	**FFP**	**IGT**	**LIHP**
FY 2011-12	**$19,932**	**$7,838**	**$12,095**	**$0**
FY 2014-15				
FY 2011-12	$98,292	$51,275	$7,905	$39,112
FY 2012-13	$118,225	$59,112	$20,000	$39,112
FY 2013-14	$59,112	$29,556	$10,000	$19,556
Total*	**$275,629**	**$139,943**	**$37,905**	**$97,781**

Funding:
Reimbursement Fund (4260-610-0995)*
LIHP MCE OON Emergency Care Services Fund (4260-610-3201)
Title XIX FFP (4260-101-0890)

*Amounts may differ due to rounding.

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	5/2008
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1078

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$84,400,000	$85,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$84,400,000	$85,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$84,400,000	$85,000,000

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.

SPA 05-023 that authorizes federal funding for this reimbursement was approved by the Centers for Medicare & Medicaid Services (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.

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 94

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 and 2014-15 payments were adjusted to incorporate the trend increase between actual payment data and prior estimate amounts.

Methodology:
1. In FY 2013-14 and 2014-15, one annual payment will be made for DPHs.

2. Reconciliation/final settlement of the first program year 2005-06 is anticipated to be completed during FY 2015-16 upon conclusion of the Physician/Non-Physician Practitioner time studies that are a required component of the reconciliation process.

(Dollars in Thousands)	Estimated Expenditures	
FY 2013-14	**TF**	**FF**
DPH 2013-14	**$ 84,400**	**$ 84,400**
FY 2014-15		
DPH 2014-15	**$ 85,000**	**$ 85,000**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,315,000	$53,645,000
- STATE FUNDS	-$246,770,000	-$286,449,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,315,000	$53,645,000
STATE FUNDS	-$246,770,000	-$286,449,000
FEDERAL FUNDS	$255,085,000	$340,094,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
SB 208 (Chapter 71, Statutes 2009), Welfare & Institutions Code 14182.3
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
Interagency Agreement 10-87249 A 03
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 91 MH/UCD & BTR —CCS and GHPP
PC 105 MH/UCD & BTR —MIA-LTC
PC 106 MH/UCD & BTR —BCCTP

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 95

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Every Woman Counts (EWC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) · Song-Brown HealthCare Workforce Training · Steven M. Thompson Physician Corps Loan Repayment Program · Mental Health Loan Assumption Program University of California* California State University* California Community Colleges*
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

* CMS approval to include the University of California (UC), California State University (CSU) and California Community Colleges (CCCs) programs as DSHPs is still pending.

The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) for a five year total of $2 billion. This claiming has first priority on the Safety Net Care Pool (SNCP) funds. In addition to the above programs, AB 1467 allows the Designated Public Hospitals (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,
- Reserved SNCP Funds for DSHP claims using DPH CPEs are no longer included in FY 2013-14. Claiming using DPH CPEs will begin in FY 2014-15.
- The final reconciliation for CMSP DY 2010-11 and DY 2011-12 was completed and resulted in additional claiming in FY 2013-14.
- The FY 2013-14 offset to the California Department of Public Health (CDPH) budget decreased based on updated data.

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 $53,561,000 ADAP FFP available, $8,315,000 is offset against the CDPH budget. In FY 2014-15, of the $58,949,000 ADAP FFP available, $53,645,000 is offset against the CDPH budget.

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 95

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 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 final reconciliation for CMSP will result in an additional $32.01 million in federal funds in FY 2013-14.

The estimated BTR DSHP federal reimbursements are as follows:

(Dollars In Thousands)	**Total DSHP (Accrual Basis)**		**Included in this PC (Cash Basis)**	
	FFP	FFP	**FFP**	**FFP**
	DY 2013-14	DY 2014-15	**FY 2013-14**	**FY 2014-15**
CCS	$77,038	$77,038		
GHPP	$44,438	$44,438		
MIA-LTC	$18,932	$18,932		
BCCTP	$1,915	$1,915		
DHCS Total	$142,323	$142,323		
ADAP	$53,561	$58,949	$53,561	$58,949
Co. Mental Health	$44,584	$46,546	$86,669	$46,546
DDS	$63,714	$63,714	$63,714	$63,714
EWC	$0	$5,796	$0	$5,796
PCTP	$907	$907	$907	$907
OSHPD	$18,224	$16,478	$18,224	$16,478
Univ. of Calif.	$0	$2,575	$0	$2,575
CSU/Comm. Colleges	$0	$29,362	$0	$29,362
CMSP	$0	$0	$32,010	$0
Reserved SNCP Funds for DSHP	$76,687	$33,350	$0	$115,767
Total Other Programs	$257,677	$257,677	$255,085	$340,094
Grand Total	$400,000	$400,000	**$255,085**	**$340,094**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$53,642,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$53,642,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$53,642,000	$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 which was effective from November 1, 2010 through December 31, 2013. AB 1628 and SB 92 authorized 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 Adult Inmate Program policy change for the Medi-Cal covered costs.

CDCR/California Correctional Health Care Services (CCHCS) forwards the applications to the Department for the purpose of determining LIHP eligibility. CDCR/CCHCS pays the hospitals under contract for covered inpatient services and provides 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.

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 96

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

- Increase in average cost per inpatient stay.
- Decrease in average monthly inmate applications.
- Updated data regarding percentage of approved LIHP applications and percentage of LIHP inmates with 2 inpatient services.

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 246 average monthly approved LIHP inpatient stays.

   - Assume the Department will process 300 applications per month of which 80% will be LIHP inmate applications.
   - Assume 96% of processed LIHP inmate applications will be approved.
   - Assume there are 230 average monthly eligible LIHP inmates.
     300 total inmate applications processed x 80% LIHP x 96% approval rate = 230
   - Assume 7% of eligible LIHP inmates will receive two inpatient hospital services during a month.
     230 approved application x 7% = 16 additional monthly inpatient stays
   - 230 LIHP approved inmate applications + 16 additional monthly stays = 246

5. Assume 14 average monthly approved inpatient stays for each LIHP.
   - 246 total average monthly inpatient stays ÷ 18 LIHPs = 14

6. The annual LIHP inmate inpatient service costs are $62,877,600 TF.
   - The average cost per inpatient stay is estimated to be $21,300
   - 246 monthly approved inpatient stays x $21,300 average cost x 12 months = $62,877,600 TF

7. For FY 2011-12, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $50,097,600.

   - Effective July 1, 2011: 2 LIHPs x 14 approved applications x $21,300 average cost x 12 months = $7,156,800
   - Effective October 1, 2011: 16 LIHPs x 14 approved applications x $21,300 average cost x 9 months = $42,940,800

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 96

8. For FY 2012-13, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $62,877,600.

9. For FY 2013-14, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $31,438,800.

10. The estimated federal fund for LIHP inmate inpatient service costs on an accrual basis:

(Dollars In Thousands)	TF	FF	CPE
FY 2011-12	$25,049	$25,049	$25,049
FY 2012-13	$31,439	$31,439	$31,439
FY 2013-14	$15,719	$15,719	$15,719

11. The Centers for Medicare and Medicaid Services (CMS) approved the claiming protocols in August 2012.

- The Department began processing payments for FY 2011-12 and FY 2012-13 in FY 2012-13.
- Remaining payments for FY 2011-12 and FY 2012-13 will be paid in FY 2013-14.
- All payments for FY 2013-14 will be paid in FY 2013-14.

The estimated payments for inmate inpatient services on a cash basis:

(Dollars In Thousands)			
FY 2013-14	**TF**	**FF**	**CPE***
FY 2011-12	$11,126	$11,126	$11,126
FY 2012-13	$26,797	$26,797	$26,797
FY 2013-14	$15,719	$15,719	$15,719
Total**	**$53,642**	**$53,642**	$53,642

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:	7/2014
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1162

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$33,635,000
- STATE FUNDS	$0	$16,817,500
PAYMENT LAG	1.0000	0.6056
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$20,369,400
STATE FUNDS	$0	$10,184,680
FEDERAL FUNDS	$0	$10,184,680

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' 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 actual expenditures through January 2014, DPH users were lower than previously projected for the period from September 2013 to January 2014. As a result, actual DPH payments for this period were also lower than previously projected. The base trend was adjusted for the updated expenditure data and resulted in a decreased base estimate for FY 2013-14 and FY 2014-15.

In addition, the base trend now includes the impact of the FY 2013-14 rate increase. The FY 2013-14 rate increase is 100% in the base and no longer in this estimate. The decrease in the cost of the FY 2014-15 rate increase is due to the updated base trend.

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. This increase is 100% in the base.

3. Assume a 4.4% increase in the FY 2014-15 interim rates.

4. An additional cost of $33,635,000 TF is estimated for FY 2014-15. The lagged cost on a cash basis is estimated to be approximately $20,369,000 TF.

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

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	7/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1698

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$24,250,000	$6,500,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,250,000	$6,500,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$24,250,000	$6,500,000

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 DY 2010-11, DY 2011-12, DY 2012-13, and DY 2013-14 HCCI money to the SNCP uncompensated care component. As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves the $400 million General Fund savings. See the BTR—Health Care Coverage Initiative Rollover Funds policy change for more information.

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 98

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.

Reason for Change from Prior Estimate:
The change is due to the delay in finalizing the claiming methodology for DY 2013-14.

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.

5. In FY 2014-15, assume the Department will rollover available funding from DY 2013-14.

6. Assume funds will be split 50/50 between the State and DPHs.

7. DPHs will receive $24.25 million in additional funding for uncompensated care costs in FY 2013-14 and $6.5 million in FY 2014-15.

(Dollars in Millions)		
FY 2013-14	**FF**	**GF**
HCCI Rollover		
DY 2012-13	($48.50)	$0.00
Amount to SNCP-DPHs	**$24.25**	**$0.00**
Amount to SNCP-DSHPs	$24.25	($24.25)
FY 2014-15		
HCCI Rollover		
DY 2013-14	($13.00)	$0.00
Amount to SNCP-DPHs	**$6.50**	**$0.00**
Amount to SNCP-DSHPs	$6.50	($6.50)

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	7/2006
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1153

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$13,988,000	$41,378,000
- STATE FUNDS	$13,988,000	$29,628,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$13,988,000	$41,378,000
STATE FUNDS	$13,988,000	$29,628,000
FEDERAL FUNDS	$0	$11,750,000

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

Stabilization for NDPHs and private hospitals is calculated; however, pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that were not paid for FY 2005-06 through FY 2009-10 to the GF. This policy change budgets the stabilization payments available for DPHs and Distressed Hospitals payments.

Reason for Change from Prior Estimate:
DY 2006-07 final reconciliations for DPHs have increased dued to updated data. In addition, the estimate is changed to include the DY 2007-08 final reconciliations in FY 2014-15.

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

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 99

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.

11. Stabilization funding is not a component of the BTR waiver. Stabilization payments will end once the DY 2009-10 final reconciliation is complete.
12. The DY 2006-07 final reconciliation for DPHs will be calculated in FY 2013-14 and paid in FY 2014-15.
13. The DY 2007-08 final reconciliation for DPHs and Distressed Hospitals will be completed and paid in FY 2014-15. It was assumed that the DPHs will have a net zero impact.

The estimated stabilization payments are:

(Dollars in Thousands)			
FY 2013-14			
DY 2005-06	**TF**	**GF**	**FF**
DPHs*	**$13,988**	**$13,988**	**$0**
FY 2014-15			
DY 2006-07			
DPHs*	$17,878	$17,878	$0
DY 2007-08			
Distressed	$23,500	$11,750	$11,750
Total	**$41,378**	**$29,628**	**$11,750**

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

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	10/2007
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1152

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,877,000	$435,143,000
- 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	$435,143,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$11,877,000	$435,143,000

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 updated program costs and the addition of 2007-08 to the FY 2014-15 estimate.

Methodology:

1. 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.

2. The final reconciliation for 2005-06 was completed and paid out in FY 2013-14. The final payout was $11,876,903.

3. The final reconciliation for 2006-07 is expected to be completed by June 2014 and is estimated to be $108,328,000. Payments will be made in FY 2014-15.

4. The final reconciliation for 2007-08 is expected to be completed and paid by June 2015 and is estimated to be $326,815,301.

(Dollars in Thousands)

	FF
FY 2013-14	
2005-06 Final Reconciliation	**$11,877**
FY 2014-15	
2006-07 Final Reconciliation	$108,328
2007-08 Final Reconciliation	$326,815
Total	**$435,143**

Funding:
100% Title XIX FFP (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,786,000	$2,370,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,786,000	$2,370,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,786,000	$2,370,000

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.

Pursuant to the Special Terms and Conditions (STCs) of the BTR waiver, for the period covering April through December of 2013, IHS facilities may claim for services provided to uninsured individuals and optional benefits eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009).

On December 24, 2013, CMS approved the extension of IHS payments for the period covering January through December 2014. Under the extension, IHS facilities may claim for optional Medi-Cal benefits eliminated, but not for services provided to uninsured individuals.

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 to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who were 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.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

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 services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For the period covering April through December of 2013, services provided to non-IHS eligible individuals are also eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements. 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

*AB 82 (Chapter 23, Statutes of 2013) restores certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration does not affect calendar year 2013. For calendar year 2014, eliminated dental services will be claimable for January 1, 2014 to April 30, 2014. Beginning May 1, 2014, restored adult dental benefits will no longer be claimable under this program.

Reason for Change from Prior Estimate:

The decrease in calendar year 2013 is due to updated data. Additionally, the estimate is changed to include the extension of the program through December 31, 2014.

Methodology:

Calendar Year 2013 Dates of Service Estimate:

1. Assume 28,826 patients are served in 2013 by the tribal health programs.

2. Assume there are no non-IHS eligibles paid at the FMAP rate.

3. Assume 15% of the 28,826 patients meet the criteria for the uninsured care and optional benefits payments for tribal health programs.

4. Assume IHS facilities provide uninsured care and optional benefits services to 4,324 IHS eligible uninsured individuals annually.

28,826 patients annually x 15% = 4,324 IHS eligible uninsured individuals

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

5. Assume the annual average number of encounters per individual is 3 for a total of 12,972 uninsured care and optional benefit encounters.

   4,324 IHS eligible individuals x 3 average encounters per person = 12,972 uninsured care and optional benefits encounters

6. The IHS global encounter rate is $330.

7. For IHS eligible individuals, the estimated total annual uncompensated care payment is $4,280,760 FF.

   12,972 encounters x $330 = $4,280,760 FF

8. Pursuant to the STCs, this claiming methodology is effective for 9 months from April 5, 2013 through December 31, 2013.

   $4,280,760 / 12 months x 9 months = $3,210,570 FF

9. 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.

10. Payments made in FY 2013-14 for the 2013 calendar year are estimated to be:

    FY 2013-14: $3,210,570 x 95% = $3,050,000 FF (Rounded)

11. Payments made in FY 2014-15 for the 2013 calendar year are estimated to be:

    FY 2014-15: $3,210,570 x 5% = $161,000 FF (Rounded)

Calendar Year 2014 Dates of Service Estimate:

12. Assume 5,364 encounters are due to uncompensated dental services provided to IHS eligible Medi-Cal beneficiaries in calendar year 2014.

13. Assume 3,621 of encounters for “All Services” are due to uncompensated optional benefits provided to IHS eligible Medi-Cal beneficiaries, not including dental services, in calendar year 2014.

14. The total uncompensated encounters for optional benefits in calendar year 2014 are estimated to be 8,985.

    5,364 dental service encounters + 3,621 encounters for other optional benefits = 8,985 optional benefits encounters

15. The IHS global encounter rate for 2014 is estimated to be $345.

16. The estimated total uncompensated care payment for optional benefits provided to Medi-Cal IHS eligible beneficiaries for calendar year 2014 is $3,099,825 FF.

    8,985 encounters x $345 = $3,099,825 FF

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

17. Assume 23.75% of payments are to be made in FY 2013-14 and 71.25% are to be made in FY 2014-15 with 5% of payments expected to be made in FY 2015-16 due to delays in claiming by IHS tribal health facilities.

18. Payments made in FY 2013-14 for the 2014 calendar year are estimated to be:

    FY 2013-14: $3,099,825 FF x 23.75% = $736,000 FF (Rounded)

19. Payments made in FY 2014-15 for the 2014 calendar year are estimated to be:

    FY 2014-15: $3,099,825 FF x 71.25% = $2,209,000 FF (Rounded)

20. The remaining 5% of payments for the 2014 calendar year will be made in FY 2015-16.

	TF	FF
FY 2013-14		
Calendar Year 2013	$3,050,000	$3,050,000
Calendar Year 2014	$736,000	$736,000
	$3,786,000	**$3,786,000**
FY 2014-15		
Calendar Year 2013	$161,000	$161,000
Calendar Year 2014	$2,209,000	$2,209,000
	$2,370,000	**$2,370,000**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$9,500,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,500,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,500,000	$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 was 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 was 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:
There is no material change.

Methodology:
1. Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	$ 8,204
Contra Costa County/Contra Costa Health Services	$ 15,250
County of Orange	$ 16,872
County of San Diego, Health and Human Services Agency	$ 13,040
County of Kern, Kern Medical Center	$ 10,000
Los Angeles County Department of Health Services	$ 54,000
San Francisco Department of Public Health	$ 24,370
San Mateo County	$ 7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	$ 20,700
Ventura County Health Care Agency	$ 10,000
Total	$180,000

2. Payments due to reallocation and related reconciliation for DY 2008-09 and DY 2009-10 under the MH/UCD HCCI are expected to be paid in FY 2013-14.

The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2013-14	**TF**	**FFP**	**CPE***
2008-09	$4,509	$4,509	$4,509
2009-10	$4,991	$4,991	$4,991
Total	**$9,500**	**$9,500**	$9,500

*Not included in TF.

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$7,600,000	$4,712,000
- STATE FUNDS	$3,800,000	$2,356,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,600,000	$4,712,000
STATE FUNDS	$3,800,000	$2,356,000
FEDERAL FUNDS	$3,800,000	$2,356,000

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:
Not Applicable

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, Item 4260-601-3096, 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).

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

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.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 103

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 (Chapter 23, Statutes of 2012) authorizes the redirection of the stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the GF. The Budget Act of 2013 redirected $538,000 TF ($269,000 GF) from NDPH supplemental payments to the GF as savings. As a result, the FY 2013-14 Appropriation amount was reduced to $3,531,000.

6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission under section 14165(b) of the W&I Code.

It is assumed NDPH supplemental payments will be made on a cash basis as follows:

FY 2013-14	**TF**	**SF**	**FF**
FY 2012-13 Ending Balance	$1,444,000	$722,000	$722,000
Appropriation (GF)	$7,600,000	$3,800,000	$3,800,000
Redirect Stabilization Fund to GF	($538,000)	($269,000)	($269,000)
Net Appropriation (GF)	$7,062,000	$3,531,000	$3,531,000
Est. FY 2012-13 Interest Earned	$4,000	$2,000	$2,000
Total Funds Available	$8,510,000	$4,255,000	$4,255,000
Cash Expenditures in FY 2013-14	**$7,600,000**	**$3,800,000**	**$3,800,000**
FY 2013-14 Ending Balance	$910,000	$455,000	$455,000
FY 2014-15			
FY 2013-14 Ending Balance	$910,000	$455,000	$455,000
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	$4,712,000	$2,356,000	$2,356,000
Cash Expenditures in FY 2014-15	**$4,712,000**	**$2,356,000**	**$2,356,000**
FY 2014-15 Ending Balance	$0	$0	$0

Funding:
100% GF (4260-104-0001)
NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
50% Title XIX / 50% NDPH Supplemental Fund (4260-601-3096/4260-101-0890)

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	104
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1072

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,949,000	$46,752,000
- 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	$46,752,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,949,000	$46,752,000

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.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 104

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the 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.

SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503. 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 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 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 final reconciliation for DY 2007-08 was added to the FY 2014-15 estimate.

Methodology:

1. The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands) **Demonstration Year**	**State-Only Funded Programs**	**Due to DPHs and SLAMSP**
2005-06	$83,151	$502,849
2006-07	$54,800	$531,200
2007-08	$76,190	$509,810
2008-09	$54,450	$531,550
2009-10	$86,910	$499,090

2. The final reconciliation for DY 2005-06 was paid in FY 2013-14.

3. The final reconciliation for DY 2006-07 will be calculated in FY 2013-14 and paid out in FY 2014-15.

4. The final reconciliation for DY 2007-08 will occur in FY 2014-15.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 104

The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)

Demonstration Year	FY 2013-14 FF	FY 2014-15 FF
2005-06	$1,949	
2006-07		$35,917
2007-08		$10,835
Total	**$1,949**	**$46,752**

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1079

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$19,327,000	-$20,118,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$19,327,000	-$20,118,000
FEDERAL FUNDS	$19,327,000	$20,118,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the Medically Indigent Adult Long-Term Care (MIA-LTC) program claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 95 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the MIA-LTC from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The MIA-LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The MIA-LTC program is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

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

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 increased 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 claimed these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the MIA-LTC programs.

3. The Department will conduct the final reconciliation for Demonstration Year (DY) 2010-11 in FY 2013-14 and estimates to claim an additional $395,000 in federal funds in FY 2013-14.

4. The final reconciliation for DY 2011-12 is anticipated to be completed in FY 2014-15. The Department estimates to claim an additional $1,186,000 in federal funds in FY 2014-15.

The MIA-LTC federal reimbursements are:

	FF
FY 2005-06	$12,834,000
FY 2006-07	$7,328,000
FY 2007-08	$14,743,000
FY 2008-09	$23,160,000
FY 2009-10	$28,147,000
FY 2010-11	$11,386,000
FY 2011-12	$33,737,000
FY 2012-13	$19,661,000
FY 2013-14	
DSHP-BTR (DY 2013-14)	$18,932,000
DY 2010-11 Final Reconciliation	$395,000
Total	**$19,327,000**
FY 2014-15	
DSHP-BTR (DY 2014-15)	$18,932,000
DY 2011-12 Final Reconciliation	$1,186,000
Total	**$20,118,000**

Funding:

100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER:	106
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1084

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,786,000	-$2,179,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,786,000	-$2,179,000
FEDERAL FUNDS	$1,786,000	$2,179,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the State-Only Breast and Cervical Cancer Treatment Program (BCCTP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 95 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established by the MH/UCD.

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the BCCTP, effective January 1, 2002, for women under 200% of the federal poverty level (FPL). BCCTP is a State-Only program that 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:
There is no change.

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 increased 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 claimed these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the BCCTP program.

3. The Department will conduct the final reconciliation for Demonstration Year (DY) 2010-11 in FY 2013-14 and estimates having to repay the federal government $129,000 in FY 2013-14. The BCCTP federal reimbursements are reduced by the final reconciliation amounts in this policy change.

4. The final reconciliation for DY 2011-12 is anticipated to be completed in FY 2014-15. The Department estimates claiming an additional $264,000 in federal funds in FY 2014-15.

The BCCTP federal reimbursements are:

	FF
FY 2005-06	$591,000
FY 2006-07	$291,000
FY 2007-08	$ 0
FY 2008-09	$1,211,000
FY 2009-10	$2,137,000
FY 2010-11	$1,095,000
FY 2011-12	$2,439,000
FY 2012-13	$1,158,000
FY 2013-14	
DSHP-BTR (DY 2013-14)	$1,915,000
DY 2010-11 Final Reconciliation	($129,000)
Total	**$1,786,000**
FY 2014-15	
DSHP-BTR (DY 2014-15)	$1,915,000
DY 2011-12 Final Reconciliation	$264,000
Total	**$2,179,000**

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 106

Funding:
100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	107
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1161

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$365,021,500	-$392,395,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$365,021,500	-$392,395,000
FEDERAL FUNDS	$365,021,500	$392,395,000

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from 50% federal financial participation (FFP) to 100% FFP to reimburse Designated Public Hospitals (DPHs).

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 97 MH/UCD & BTR — DPH Interim Rate Growth

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs no longer receive the negotiated per diem rates under the Selective Provider Contracting Program (SPCP) for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Instead, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The previous SPCP negotiated per diem rates were paid with 50% FFP and 50% GF. Typically, the items in the Medi-Cal Estimate base trend are paid with 50% FFP and 50% GF. Since the DPH interim rate is paid with 100% FFP, an adjustment to shift from 50% GF to 100% FFP must be made in the base estimate data.

Reason for Change from Prior Estimate:
Based on actual expenditures through January 2014, DPH users were lower than previously projected for the period from September 2013 to January 2014. As a result, actual DPH payments for this period were also lower than previously projected. The base trend was adjusted for the updated expenditure data and resulted in a decreased base estimate for FY 2013-14 and FY 2014-15.

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 107

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)	Expenditures	GF to FF shift
FY 2013-14	**$730,043**	**$365,021**
FY 2014-15	**$784,790**	**$392,395**

Funding:

50% Title XIX / 50% GF (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$24,250,000	-$6,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$24,250,000	-$6,500,000
FEDERAL FUNDS	$24,250,000	$6,500,000

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 DY 2010-11, DY 2011-12, DY 2012-13, and DY 2013-14 HCCI money to the SNCP uncompensated care component. 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. See the BTR—Health Care Coverage Initiative Rollover Funds policy change for more information.

BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 108

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.

Reason for Change from Prior Estimate:
The change is due to the delay in finalizing the claiming methodology for DY 2013-14.

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.

5. In FY 2014-15, assume the Department will rollover available funding from DY 2013-14.

6. Assume funds will be split 50/50 between the state and DPHs.

7. General Fund savings of $24.25 million and $6.5 million are expected in FY 2013-14 and FY 2014-15, respectively.

(Dollars in Millions)		
FY 2013-14	**FF**	**GF**
HCCI Rollover		
DY 2012-13	($48.50)	$0.00
Amount to SNCP-DPHs	$24.25	$0.00
Amount to SNCP-DSHPs	**$24.25**	**($24.25)**
FY 2014-15		
HCCI Rollover		
DY 2013-14	($13.00)	$0.00
Amount to SNCP-DPHs	$6.50	$0.00
Amount to SNCP-DSHPs	**$6.50**	**($6.50)**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	7/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1459

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$24,503,000	-$8,959,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$24,503,000	-$8,959,000
FEDERAL FUNDS	-$24,503,000	$8,959,000

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 in FY 2013-14 are due to updated program expenditures and the addition of the Demonstration Year (DY) 5 final reconciliation for the County Medical Services Program (CMSP). The estimate was also changed to include the DY 5 final reconciliation for the County Mental Health Services for the Uninsured (CMHS) program in FY 2014-15.

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).

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 110

2. AB 1653 (Chapter 218, Statutes of 2010) allowed 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 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.

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

The General Fund costs/savings resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)	TF	GF	FF	ARRA
FY 2013-14				
CMHS	$0	($22,152)	$17,983	$4,169
DY 5 EAPC Final Reconciliation	$0	($78)	$63	$15
DY 5 ADAP Final Reconciliation	$0	$26,983	($21,905)	($5,078)
DY 5 CMSP Final Reconciliation	$0	$19,750	($16,034)	($3,716)
Total	**$0**	**$24,503**	**($19,893)**	**($4,610)**
FY 2014-15				
DY 5 CMHS Final Reconciliation	**$0**	**($8,959)**	**$7,273**	**$1,686**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	7/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1694

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$48,500,000	-$13,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$48,500,000	-$13,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$48,500,000	-$13,000,000

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 DY 2010-11, DY 2011-12, DY 2012-13, and DY 2013-14 HCCI money to the SNCP uncompensated care component. 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.

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 112

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 (DSHPs) for more information.

Reason for Change from Prior Estimate:
The change is due to the delay in finalizing the claiming methodology for DY 2013-14.

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.

5. In FY 2014-15, assume the Department will rollover available funding from DY 2013-14.

6. Assume funds will be split 50/50 between the State and DPHs.

(Dollars in Millions)

FY 2013-14	**FF**	**GF**
HCCI Rollover		
DY 2012-13	**($48.50)**	**$0.00**
Amount to SNCP-DPHs	$24.25	$0.00
Amount to SNCP-DSHPs	$24.25	($24.25)
FY 2014-15		
HCCI Rollover		
DY 2013-14	**($13.00)**	**$0.00**
Amount to SNCP-DPHs	$6.50	$0.00
Amount to SNCP-DSHPs	$6.50	($6.50)

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$106,398,000	-$212,344,000
- STATE FUNDS	-$53,199,000	-$106,172,000
PAYMENT LAG	0.7595	0.8732
% REFLECTED IN BASE	75.78 %	35.37 %
APPLIED TO BASE		
TOTAL FUNDS	-$19,572,000	-$119,836,200
STATE FUNDS	-$9,786,000	-$59,918,080
FEDERAL FUNDS	-$9,786,000	-$59,918,080

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:
SB 853 mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon DRGs. The DRG payment methodology replaces the previous payment methods.

Previously, private hospitals and NDPHs received 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 previous payment system, these hospitals billed Medi-Cal the daily inpatient service charges on a per day usage. Providers received payment for the actual number of days a beneficiary remained 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

NDPHs continued to receive payments under the previous methodology through December 31, 2013. These hospitals transitioned 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.

Methodology:

1. The DRG payment methodology was implemented on July 1, 2013 for private hospitals.

2. The DRG payment methodology was implemented on January 1, 2014 for NDPHs.

3. Using the community inpatient service category base estimate, adjusted to remove Designated Public Hospital expenditures, and incorporating relative policy changes;
    - FY 2013-14 expenditures under the prior methodology are estimated to be $3,317,010,000 TF for private hospitals and $174,580,000 TF for NDPHs.

    - FY 2014-15 expenditures under the prior methodology are estimated to be $3,417,659,000 TF for private hospitals and $179,877,000 TF for NDPHs.

4. FY 2013-14 FFS payments under the DRG payment system are frozen at the July 1, 2013 level and are estimated to be $3,201,444,000 TF for private hospitals. FY 2013-14 NDPH FFS payments under the DRG system are for 6 months, due to the implementation date of January 1, 2014 and are estimated to be $96,458,000 TF for NDPHs.

5. FY 2014-15 FFS payments under the DRG payment system are frozen at the July 1, 2013 level and are estimated to be $3,201,444,000 TF for private hospitals and $183,748,000 TF for NDPHs.

6. Private hospital FFS savings in FY 2013-14 are estimated to be:

    $3,317,010,000 - $3,201,444,000 = $115,566,000 TF ($57,783,000 GF)

7. Private hospital FFS savings in FY 2014-15 are estimated to be:

    $3,417,659,000 - $3,201,444,000 = $216,215,000 TF ($108,107,500 GF)

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 113

The DRG net savings are as follows:

(Dollars in Thousands)	TF	GF	FF
FY 2013-14 Annual			
Private FFS	($115,566)	($57,783)	($57,783)
NDPH FFS	$9,168	$4,584	$4,584
Total net savings	**($106,398)**	**($53,199)**	**($53,199)**

(Dollars in Thousands)	TF	GF	FF
FY 2014-15 Annual			
Private FFS	($216,215)	($108,108)	($108,107)
NDPH FFS	$3,871	$1,936	$1,935
Total net savings	**($212,344)**	**($106,172)**	**($106,172)**

Funding:
50% Title XIX / 50% GF (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$798,599,000	$1,481,657,000
- STATE FUNDS	$331,195,000	$521,697,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$798,599,000	$1,481,657,000
STATE FUNDS	$331,195,000	$521,697,000
FEDERAL FUNDS	$467,404,000	$959,960,000

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 2014-15.

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.

3. The premium revenue was multiplied by the MCO tax amount of 3.9375% to determine total tax revenue.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 117

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)	TF	MCO Tax	FFP
FY 2013-14	**$798,599**	$331,578	$467,021
FY 2014-15	**$1,481,657**	$533,489	$948,168

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

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1054

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$739,514,000	$860,767,000
- STATE FUNDS	$343,686,000	$400,038,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$739,514,000	$860,767,000
STATE FUNDS	$343,686,000	$400,038,000
FEDERAL FUNDS	$395,828,000	$460,729,000

DESCRIPTION

Purpose
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities 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

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 118

Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010. The IGT will continue on an ongoing basis.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; 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 Fresno, Stanislaus, and Tulare Counties were effective retroactive to October 1, 2011. 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 tax on the total operating revenue of Medi-Cal Managed Care plans effective July 1, 2013, through June 30, 2016.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to General Fund policy change.

(Dollars in Thousands)

FY 2013-14

	IGT*	Regular FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	**$343,686**	**$325,170**	**$24,957**	**$45,701**	**$395,828**	**$739,514**

FY 2014-15

	IGT*	Regular FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	**$400,038**	**$378,486**	**$29,048**	**$53,195**	**$460,729**	**$860,767**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
Reimbursement (4260-610-0995)*

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1766

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$98,877,000	$6,901,009,000
- STATE FUNDS	$49,438,500	$3,450,504,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$98,877,000	$6,901,009,000
STATE FUNDS	$49,438,500	$3,450,504,500
FEDERAL FUNDS	$49,438,500	$3,450,504,500

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 CCI-Transfer of IHSS Costs to CDSS
PC 143 CCI-Savings and Deferral
PC 197 CCI-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.

CCI-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:
There are several changes that have occurred. First, the Department has delayed the schedule for some participating counties. Second, this estimate assumes the Department's Dual-Eligible Special Needs Plans (D-SNP) policy proposal. Third, managed care payments are now included in this policy change for the excluded Cal MediConnect (CMC) populations. Lastly, this policy change is using updated draft CMC capitation rates and MLTSS capitation rates for eligible CMC populations prior to the demonstration.

Methodology:

1. Assume dual eligibles in the Medicare fee-for-service (FFS) program receiving LTC institutional and community-based services under the traditional Fee-for-Service (FFS) model will passively enroll into the CCI no later than January 1, 2015. Depending on the county, eligibles will phase-in over 12 months or all at once.

2. Assume dual eligibles in Medicare Advantage (MA) plans that are also CMC plans will passively enroll into the CCI on January 1, 2015. There is no phase-in assumed for this population.

3. Assume Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all excluded CMC dual eligibles (including non-CMC D-SNP) will have their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015. Depending on the county and coverage type, eligibles may phase-in over 12 months or all at once.

4. Assume there are an estimated 1,267,004 beneficiaries as of January 1, 2015 who will be eligible for a managed care plan in the eight pilot counties. Of the 1,267,004 beneficiaries, 762,424 will have already enrolled in a managed care plan. Of the 762,424 enrolled beneficiaries, 207,671 are dual eligibles who will passively enroll into CMC.

5. Assume for participating dual eligibles, there will an overall average 1.15% savings in FY 2013-14 in FY 2014-15.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 119

6. Estimated below is the overall impact of the Dual and LTC Integration proposal in FY 2013-14 and FY 2014-15.

(Dollars in Thousands) **FY 2013-14**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	**$98,877**	**$49,439**	**$49,439**	**$0**
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($36,593)	($18,296)	($18,296)	$0
Defer Managed Care Payment	($39,437)	($19,718)	($19,718)	$0
Total	($76,030)	($38,015)	($38,015)	$0
IHSS FFS Savings (In the Base)	($19,237)	$0	($19,237)	$0
Delay 1 Checkwrite (In the Base)	$2,463	$1,231	$1,231	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($19,237)	$0	$19,237
CCI-Transfer of IHSS Costs to CDSS (PC 123)	$39,821	$0	$0	$39,821
CCI-Administrative Costs (OA 19)	$9,217	$2,759	$6,459	$0
Total of CCI PCs including pass through	$55,111	($3,823)	($123)	$59,058

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	**$6,901,009**	**$3,450,504**	**$3,450,504**	**$0**
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($3,538,604)	($1,769,302)	($1,769,302)	$0
Defer Managed Care Payment	($963,695)	($481,848)	($481,848)	$0
Total	($4,502,299)	($2,251,150)	($2,251,150)	$0
IHSS FFS Savings (In the Base)	($1,206,125)	$0	($1,206,125)	$0
Delay 1 Checkwrite (In the Base)	$80,284	$40,142	$40,142	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,206,125)	$0	$1,206,125
CCI-Transfer of IHSS Costs to CDSS (PC 123)	$2,496,678	$0	$0	$2,496,678
CCI-Administrative Costs (OA 19)	$8,086	$2,551	$5,535	$0
Total of CCI PCs including pass through	$3,777,633	$35,923	$38,907	$3,702,803

Funding:

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

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER:	120
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1588

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$783,992,000	$431,688,000
- STATE FUNDS	$391,996,000	$215,844,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$783,992,000	$431,688,000
STATE FUNDS	$391,996,000	$215,844,000
FEDERAL FUNDS	$391,996,000	$215,844,000

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, Seniors and Persons with Disabilities (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 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

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 120

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 General Fund Reimbursements from DPHs Policy Change. 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 as which Public Providers are affected. Because Managed Care plan years are changing to align with state fiscal years, Year 3 payments will now be made in FY 2013-14. Additionally, a placeholder for Year 4 payments has been estimated for FY 2014-15.

Methodology:
<u>Inpatient Hospital Services</u>

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 were 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 IGTs in the amount of $199,855,000 were paid by the DPHs in FY 2013-14.
4. The Year 3 IGTs 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 estimated IGTs have not yet been determined; therefore, a placeholder in the amount of $170,222,000 is estimated for FY 2013-14.
5. The Year 4 IGTs include the period July 1, 2014, through June 30, 2015, for both the GMC model and Two-Plan model counties. The estimated IGTs have not yet been determined; therefore a placeholder in the amount of $215,844,000 is estimated for FY 2014-15.

(In Thousands)	IGT	FFP	TF
FY 2013-14			
Year 1 (amended)	$21,919	$21,919	$43,838
Year 2	$199,855	$199,855	$399,710
Year 3	$170,222	$170,222	$340,444
Total	**$391,996**	**$391,996**	**$783,992**
FY 2014-15	**$215,844**	**$215,844**	**$431,688**

Funding:
100% Title XIX 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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$371,327,000	$0
- STATE FUNDS	$185,663,500	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$371,327,000	$0
STATE FUNDS	$185,663,500	$0
FEDERAL FUNDS	$185,663,500	$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)

	TF	Gross Premium Tax	FFP
FY 2013-14	**$371,327**	$185,663	$185,664

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

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1653

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$39,821,000	$2,496,678,000
- STATE FUNDS	$39,821,000	$2,496,678,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$39,821,000	$2,496,678,000
STATE FUNDS	$39,821,000	$2,496,678,000
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.

CCI-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:
There are several changes that have occurred. First, the Department has delayed the schedule for some participating counties. Second, this estimate assumes the Department's Dual-Eligible Special Needs Plans (D-SNP) policy proposal. Lastly, draft capitations assume a higher percentage of the monthly capitation is for IHSS services.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2013-14 and FY 2014-15.

(Dollars in Thousands) **FY 2013-14**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	$98,877	$49,439	$49,439	$0
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($36,593)	($18,296)	($18,296)	$0
Defer Managed Care Payment	($39,437)	($19,718)	($19,718)	$0
Total	($76,030)	($38,015)	($38,015)	$0
IHSS FFS Savings (In the Base)	($19,237)	$0	($19,237)	$0
Delay 1 Checkwrite (In the Base)	$2,463	$1,231	$1,231	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($19,237)	$0	$19,237
CCI-Transfer of IHSS Costs to CDSS	**$39,821**	**$0**	**$0**	**$39,821**
CCI-Administrative Costs (OA 19)	$9,217	$2,759	$6,459	$0
Total of CCI PCs including pass through	$55,111	($3,823)	($123)	$59,058

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	$6,901,009	$3,450,504	$3,450,504	$0
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($3,538,604)	($1,769,302)	($1,769,302)	$0
Defer Managed Care Payment	($963,695)	($481,848)	($481,848)	$0
Total	($4,502,299)	($2,251,150)	($2,251,150)	$0
IHSS FFS Savings (In the Base)	($1,206,125)	$0	($1,206,125)	$0
Delay 1 Checkwrite (In the Base)	$80,284	$40,142	$40,142	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,206,125)	$0	$1,206,125
CCI-Transfer of IHSS Costs to CDSS	**$2,496,678**	**$0**	**$0**	**$2,496,678**
CCI-Administrative Costs (OA 19)	$8,086	$2,551	$5,535	$0
Total of CCI PCs including pass through	$3,777,633	$35,923	$38,907	$3,702,803

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 123

Funding:
100% Reimbursement (4260-610-0995)

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1788

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$337,849,000
- STATE FUNDS	$0	$168,924,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$337,849,000
STATE FUNDS	$0	$168,924,500
FEDERAL FUNDS	$0	$168,924,500

DESCRIPTION

Purpose:
This policy change estimates retroactive 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, County Organized Health Systems (COHS), and Geographic Managed Care (GMC). In addition, retroactive rate changes for Seniors and Persons with Disabilities (SPDs) impact rate periods from July 2011 through September 2013 for Two-Plan model plans and July 2011 through December 2013 for GMC plans. Capitation rate increases will be paid in FY 2014-15.

Reason for Change from Prior Estimate:
Addition of FY 2010-11 retro rate adjustments and corrected rates.

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 2014-15.

2. A comparison between rates paid for SPDs for July 2011 through September 2013 for Two Plan model plans and July 2011 through December 2013 for GMC plans was used to determine additional amounts that should be paid in FY 2014-15.

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 124

(Dollars in Thousands)

FY 2014-15	2010-11 and 2011-12 Retro Rate Adjustments	2012-13 Retro Rate Adjustments	TF	GF	FF
Two Plan	$91,130	$208,321	$299,451	$149,725	$149,726
COHS	$0	$10,472	$10,472	$5,236	$5,236
GMC	$14,593	$13,333	$27,926	$13,963	$13,963
Total	$105,723	$232,126	**$337,849**	**$168,924**	**$168,925**

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

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	11/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1651

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,079,000	-$26,934,000
- STATE FUNDS	$539,500	-$13,467,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,079,000	-$26,934,000
STATE FUNDS	$539,500	-$13,467,000
FEDERAL FUNDS	$539,500	-$13,467,000

DESCRIPTION

Purpose:
This policy change estimates the savings related to expanding managed care for Seniors and Persons with Disabilities (SPDs) into rural counties that were previously 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 was previously in 30 counties. AB 1467 expanded 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 was implemented using two models, County Organized Health Systems (COHS) and a Regional Model, including San Benito and Imperial counties.

Reason for Change from Prior Estimate:
Rates and eligibles have been updated. COHS expansion populations have been transitioned into PC 115 County Organized Health Systems. Non-SPD populations in the Regional model counties have been transitioned into PC 215 Regional Model.

Methodology:
1. The expansion occurred on November 1, 2013, for the Regional model, which includes the 20 counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba. SPD beneficiaries in all Regional counties have the option to enroll in managed care and it was assumed

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 127

less than 1% would enroll. No earlier than August 31, 2014, all non-dual SPDs will be required to enroll. Dual SPDs will retain the option to enroll, and it is assumed that less than 1% would remain enrolled. All other beneficiaries in the Regional counties were mandatorily enrolled on the implementation date.

2. Non-dual SPDs in San Benito County will retain the ability to opt out after mandatory enrollment, and it is assumed less than 1% would remain enrolled.

3. Assume that costs for the Regional expansions will be 99% of current FFS costs.

4. The expansion of managed care will result in a cost in FY 2013-14 on a cash basis because capitation payments begin immediately, while FFS payments continue for services provided before the expansion due to the time it takes providers to bill for services. The costs for FY 2013-14 and savings for FY 2014-15 are expected to be:

FY 2013-14	
Managed Care Capitation Payments	$8,648,000
Managed Care Deferral	($1,081,000)
FFS Savings	($8,735,000)
FFS Payment Lag	.7428
FFS Lagged Savings	($6,488,000)
FY 2013-14 Cost	**$1,079,000**
FY 2014-15	
Managed Care Capitation Payments	$291,533,000
Managed Care Deferral	($28,820,000)
FFS Savings	($293,386,000
FFS Payment Lag	.9873
FFS Lagged Savings	($289,647,000)
FY 2014-15 Savings	**($26,934,000)**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,236,000	$0
- STATE FUNDS	$4,050,050	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,236,000	$0
STATE FUNDS	$4,050,050	$0
FEDERAL FUNDS	$4,185,950	$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 121 Extend Gross Premium Tax – Increase Capitation Rates. 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 IGT contributions being less than expected in some counties. The GPT for the 2012-13 IGTs are budgeted in PC 134 Extend Gross Premium Tax.

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:

	FY 2013-14
50% Title XIX / 50% GF (4260-101-0001/0890)	$7,783,000
65% Title XXI / 35% GF (4260-113-0890)	$453,000
Total	**$8,236,000**

NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	7/1998
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	95

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

DESCRIPTION

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

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

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

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

Methodology:
Not Applicable

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

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

DESCRIPTION

Purpose:
The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2014-15.

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 shows the increase in capitation rates from FY 2013-14 to FY 2014-15.

Reason for Change from Prior Estimate:
Updated rates have been incorporated into the Base PCs. This policy change is now information only showing the rate increase from FY 2013-14 to FY 2014-15.

CAPITATED RATE ADJUSTMENT FOR FY 2014-15

REGULAR POLICY CHANGE NUMBER: 132

Methodology:

1. Rates for FY 2013-14 and FY 2014-15 were multiplied by FY 2013-14 eligibles for Two Plan, COHS, and GMC counties. The difference between the two shows the rate increase without the effect of eligibles changing.

2. The impact of AB 97 and Mental Health Expansion was excluded from this comparison. Both of these items have a partial year impact in FY 2013-14, while they have a full-year impact in FY 2014-15.

3. The cost by plan includes the dollars for the Healthy Families Program transition into managed care.

(Rounded)	Cost by Plan	Rate Adjustment	Rate Increase
COHS	$3,751,405,000	1.6%	**$59,506,000**
Two Plan	$7,745,327,000	2.0%	**$156,984,000**
GMC	$1,299,587,000	13.0%	**$168,440,000**
Total	$12,796,319,000	3.0%	**$384,930,000**

Funding:
Not Applicable.

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	2/2011
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1586

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

DESCRIPTION

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

Authority:
AB 1422 (Chapter 157, Statutes of 2009)
SB 853 (Chapter 717, Statutes of 2010)
ABX1 21 (Chapter 11, Statutes of 2011)
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 128 Increase in Capitation Rates for Gross Premium Tax
PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 140 MCO Tax Managed Care Plans

Background:
AB 1422 imposed a Gross Premium Tax (GPT) on the total operating revenue of Medi-Cal Managed Care plans. The proceeds from the tax are used to offset the capitation rates. The FY 2011-12 impact of the increase in capitation payments related to the GPT is included in the Increase in Capitation Rates for Gross Premium Tax policy change.

The GPT imposed by AB 1422 was effective retroactively to January 1, 2009, through December 31, 2010. SB 853 extended the GPT through June 30, 2011. ABX1 21 extended the GPT through June 30, 2012. SB 78 extended the GPT through July 1, 2013; however, the GPT for this extension period is budgeted in the Extend Gross Premium Tax – Incr. Capitation Rates policy change. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period and will be matched with federal funds at the level in effect at that time.

Capitation rate increases due to the GPT are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the GPT fund on a quarterly basis.

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 133

These funding adjustments reflect GPT amounts that were used to increase capitation rates in prior periods.

The GPT dollars come from the FY 2011-12 Ventura IGT, the FY 2011-12 GMC IGT, and the FY 2011-12 Two-Plan IGT, which are being paid in 2013-14. The GPT for the FY 2012-13 IGTs is budgeted in the Extend Gross Premium Tax – Incr. Capitation Rates policy change.

Reason for Change from Prior Estimate:
Changes are due to the IGT contributions being less than expected..

Methodology:
1. Funding adjustments for FY 2013-14 will be made in the amount of $4,050,000 for FY 2011-12 IGTs.

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

	FY 2013-14
Total Gross Premium Tax	$4,050,000
GF	($4,050,000)
Total	**$0**

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

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1647

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

DESCRIPTION

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 $185,664,000. Of this amount MRMIB will receive $128,102,000. The Department will receive $57,562,000.

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 134

The gross premium tax fund transfers to the GF are expected to be:

FY 2013-14	TF	GF	Gross Premium Tax
Gross Premium Tax	**$0**	($185,664,000)	$185,664,000
Amount to MRMIB	**$0**	$128,102,000	($128,102,000)
Total	**$0**	($57,562,000)	$57,562,000

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

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

DESCRIPTION

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

Authority:
AB 102 (Chapter 29, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

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.

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

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 135

2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.

(Dollars In Thousands)	IGT amount subject to the fee	20% Admin. & Processing Fee		Support Cost Reimbursement to GF		Local Assistance Reimbursement to GF
FY 2013-14	$ 302,780	$ 60,556	-	$ 251	=	**$ 60,305**
FY 2014-15	$ 371,045	$ 74,209	-	$ 251	=	**$ 73,958**

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

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

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will reimburse the General Fund (GF) for the costs built into the managed care baseline capitation rates.

Authority:
SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
Effective June 1, 2011, SPDs who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Since 2005, the inpatient care for fee-for-service (FFS) members receiving services at a DPH facility has been reimbursed under a cost-based payment and financing structure. The DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided. It is important to note that as a result of this funding arrangement, the State was not providing the state\local match requirement. Instead, the CPE process satisfied the state\local match requirement. Due to this payment structure, the transition of FFS Seniors and Persons with Disabilities (SPDs) to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while at the same time ensuring that there are not new State GF expenditures. Other, non-inpatient services provided within the FFS structure by a DPH or its affiliated governmental entities (collectively, Public Providers) were being reimbursed through a combination of regulatory FFS rates, for which the nonfederal share was supported with State GF, and supplemental reimbursement above the FFS fee schedule, financed through the CPE mechanism, for the otherwise unreimbursed allowable costs of the services. The services for which these FFS supplemental

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 136

reimbursement mechanisms apply include hospital outpatient, physician and non-physician practitioner professional, and non-hospital clinic services but does not include federally qualified health center (FQHC) services. These FFS payment structures no longer occur with respect to SPD beneficiaries that have transitioned to the managed care payment environment. Therefore, appropriate rate and other funding adjustments needed to be developed to reflect the historical patient reimbursement provided by these FFS methodologies in order to ensure access to services and adequate funding to these critical safety net providers.

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs.

In FY 2012-13, the DPHs began reimbursing the GF through an IGT for costs that are built into the managed care baseline capitation rates that would not have been incurred had the SPDs remained in FFS.

Reason for Change from Prior Estimate:
Because Managed Care plan years are changing to align with state fiscal years, Year 3 payments will now be made in FY 2013-14. Additionally, a placeholder for Year 4 payments has been estimated for 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. A reimbursement in the amount of $86,847,000 was made in FY 2012-13.

7. The Year 2 reimbursement includes the period of January 1, 2013, through December 31, 2013, for the GMC model counties, and October 1, 2012, through September 30, 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 includes 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 $61,842,000 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. The reimbursement has not yet been calculated; therefore, a placeholder in the amount of $83,654,000 is estimated for FY 2014-15.

	FY 2013-14	FY 2014-15
Year 2 Reimbursement from DPHs	$ 80,436,000	$ 0
Year 3 Reimbursement from DPHs	$ 0	$ 61,842,000
Year 4 Reimbursement from DPHs	$ 0	$ 83,654,000
Total Reimbursement	$ 80,436,000	$ 145,496,000
GF	($ 80,436,000)	($ 145,496,000)
Net Impact	**$ 0**	**$ 0**

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

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds from the Gross Premium Tax Fund to the General Fund as a result of a proposal to extend the Gross Premium Tax.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and extended the collection of a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2013. The proceeds from the tax are used to offset capitation rates. Due to a delay in approval, the FY 2012-13 transfer is not expected to occur until FY 2013-14.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis.

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

Methodology:
1. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. Assume that transfers from the Department of Insurance take place three months after quarterly tax payments.

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 137

The gross premium tax fund transfers to the GF are expected to be:

	TF	GF	Gross Premium Tax
FY 2013-14	**$0**	$ (185,664,000)	$ 185,664,000

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

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

DESCRIPTION

Purpose:
This policy change is for informational purposes only.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Updated FFS payment information.

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 138

Methodology:
In Fiscal Year 2012-2013 FFS payments for managed care enrollees totaled:

	Expenditures by Aid Category		
	Other	**CCS/GHPP**	**Total**
Families	$398,118,000	$517,219,000	$915,337,000
Disabled	$381,271,000	$570,039,000	$951,310,000
Aged	$97,347,000	$0	$97,347,000
200% Poverty	$13,982,000	$32,408,000	$46,390,000
MI Child	$10,026,000	$19,852,000	$29,878,000
133% Poverty	$12,695,000	$11,696,000	$24,391,000
Other	$1,862,000	$17,000	$1,879,000
100% Poverty	$11,496,000	$25,418,000	$36,914,000
Blind	$9,803,000	$14,429,000	$24,232,000
MI Adult	$2,461,000	$481,000	$2,942,000
Totals	**$939,061,000**	**$1,191,559,000**	**$2,130,620,000**

Funding:
Not Applicable

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1782

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

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

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be retained by the Department to offset GF cost for capitated rate increases as a result of the imposition of the tax. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change from Prior Estimate:
Updated FY 2013-14 rates and new FY 2014-15 rates.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 139

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans– Incr. Cap. Rates policy change.

6. Adjustment amounts include the impact of the ACA Optional and Mandatory Expansions.

The MCO tax fund transfers to the GF are expected to be:

	TF	GF	MCO Tax
FY 2013-14	**$ 0**	$ (252,057,000)	$ 252,057,000
FY 2014-15	**$ 0**	$ (488,398,000)	$ 488,398,000

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

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2013.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

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

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be continuously appropriated to the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates GF savings resulting from the imposition of the MCO tax.

Reason for Change from Prior Estimate:
Updated FY 2013-14 rates and new FY 2014-15 rates.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 140

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

6. The impact of the MCO tax is included in the ACA Optional Expansion and the ACA Mandatory Expansion policy changes.

The MCO tax fund transfers to the GF are expected to be:

	TF	GF	MCO Tax
FY 2013-14	**$ 0**	$ (248,396,000)	$ 248,396,000
FY 2014-15	**$ 0**	$ (474,072,000)	$ 474,072,000

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

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

DESCRIPTION

Purpose:
This policy change estimates the capitated payments associated with the transition of Medi-Cal beneficiaries out of Senior Care Action Network (SCAN) and into Coordinate Care Initiative (CCI) managed care plans.

Authority:
Welfare & Institutions Code 14204

Interdependent Policy Changes:
Not Applicable

Background:
SCAN is a Medicare Advantage Special Needs Plan and contracts with the Department to coordinate and provide health care services on a capitated basis for persons aged 65 and older with both Medicare and Medi-Cal coverage in Los Angeles, San Bernardino, and Riverside counties.

The Department does not plan to renew the SCAN contract. The Department executed a one-year contract extension for January 1, 2014 through December 31, 2014. The contract extension facilitates transition of the SCAN Medi-Cal population into CCI managed care plans.

Reason for Change from Prior Estimate:
Update eligible data from August 2013 to February 2014 resulted in new projections of plan enrollment.

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 managed care plan.

SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 141

4. Assume SCAN beneficiaries will continue to enroll into managed care plans for the period of January 1, 2015 through June 30, 2015 at the same rate as during FY 2013-14.

5. The managed care rates used to estimate these costs are based on a weighted average of managed care rates by aid code for Los Angeles, Riverside, and San Bernardino counties.

6. The Department does not anticipate a fiscal impact.

FY 2014-15	Eligible Months	Managed Care	SCAN	Total
Los Angeles	31,840	$13,836,000	($13,836,000)	$0
Riverside	10,170	$4,033,000	($4,033,000)	$0
San Bernardino	6,432	$2,788,000	($2,788,000)	$0
Total	48,442	$20,657,000	($20,657,000)	**$0**

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

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1482

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$1,071,000
- STATE FUNDS	$0	-$535,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$1,071,000
STATE FUNDS	$0	-$535,500
FEDERAL FUNDS	$0	-$535,500

DESCRIPTION

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

Authority:
Contract 08-85215

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 July 1, 2014.

Reason for Change from Prior Estimate:
Updated rates and implementation date.

Methodology:
1. It is assumed the annual member months for undocumented beneficiaries in FY 2014-15 will be 3,430 for Solano County, 1,718 for Napa County, and 1,880 for Yolo County.

2. The FY 2014-15 undocumented beneficiary rates are assumed to be $373.85 for Solano County, $671.87 for Napa County, and $512.92 for Yolo County.

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 142

3. The FY 2014-15 cost, for period July 1, 2014 through June 30, 2015, for undocumented beneficiaries by county is expected to be:

Solano County:	3,430 x $373.85 = $ 1,282,000
Napa County:	1,718 x $671.87 = $ 1,154,000
Yolo County:	1,880 x $512.92 = $ 964,000

$1,282,000 + $1,154,000 + $964,000 = $3,400,000

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

FY 2014-15	$3,400,000	FFS cost
	($3,400,000)	Managed Care savings
	$0	FY 2014-15 impact of shift to FFS

5. There will be a net savings in FY 2014-15 due to the capitation payments ending on June 30, 2014. There will be a lag in FFS payments due to the time it takes for providers to bill and be paid for services.

	FY 2014-15
FFS Cost	$3,400,000
FFS Payment Lag	0.6849
Lagged FFS Costs	$2,329,000
Managed Care Savings	($3,400,000)
Lagged FFS Costs	$2,329,000
Net Costs (Rounded)	**($1,071,000)**

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

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1641

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$76,030,000	-$4,502,299,000
- STATE FUNDS	-$38,015,000	-$2,251,149,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$76,030,000	-$4,502,299,000
STATE FUNDS	-$38,015,000	-$2,251,149,500
FEDERAL FUNDS	-$38,015,000	-$2,251,149,500

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 123 CCI-Transfer of IHSS Costs to CDSS
PC 119 CCI-Managed Care Payments
PC 197 CCI-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) 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.

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER: 143

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

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:
There are several changes that have occurred. First, the Department has delayed the schedule for some participating counties. Second, this estimate assumes the Department's Dual-Eligible Special Needs Plans (D-SNP) policy proposal. Lastly, FFS savings are now included in this policy change for the excluded Cal MediConnect (CMC) populations.

Methodology:

1. Assume dual eligibles in the Medicare fee-for-service (FFS) program receiving LTC institutional and community-based services under the traditional Fee-for-Service (FFS) model will passively enroll into the CCI no later than January 1, 2015. Depending on the county, eligibles will phase-in over 12 months or all at once.

2. Assume dual eligibles in Medicare Advantage (MA) plans that are also CMC plans will passively enroll into the CCI on January 1, 2015. There is no phase-in assumed for this population.

3. Assume Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all excluded CMC dual eligibles (including non-CMC D-SNP) will have their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015. Depending on the county and coverage type, eligibles may phase-in over 12 months or all at once.

4. Assume there are an estimated 1,267,004 beneficiaries as of January 1, 2015 who will be eligible for a managed care plan in the eight pilot counties. Of the 1,267,004 beneficiaries, 762,424 will have already enrolled in a managed care plan. Of the 762,424 enrolled beneficiaries, 207,671 are dual eligibles who will passively enroll into CMC.

5. Assume for participating dual eligibles, there will an overall average 1.15% savings in FY 2013-14 in FY 2014-15.

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER: 143

6. Estimated below is the overall impact of the Dual and LTC Integration proposal in FY 2013-14 and FY 2014-15.

(Dollars in Thousands) **FY 2013-14**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	$98,877	$49,439	$49,439	$0
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($36,593)	($18,296)	($18,296)	$0
Defer Managed Care Payment	($39,437)	($19,718)	($19,718)	$0
Total	**($76,030)**	**($38,015)**	**($38,015)**	**$0**
IHSS FFS Savings (In the Base)	($19,237)	$0	($19,237)	$0
Delay 1 Checkwrite (In the Base)	$2,463	$1,231	$1,231	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($19,237)	$0	$19,237
CCI-Transfer of IHSS Costs to CDSS (PC 123)	$39,821	$0	$0	$39,821
CCI-Administrative Costs (OA 19)	$9,217	$2,759	$6,459	$0
Total of CCI PCs including pass through	$55,111	($3,823)	($123)	$59,058

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	$6,901,009	$3,450,504	$3,450,504	$0
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($3,538,604)	($1,769,302)	($1,769,302)	$0
Defer Managed Care Payment	($963,695)	($481,848)	($481,848)	$0
Total	**($4,502,299)**	**($2,251,150)**	**($2,251,150)**	**$0**
IHSS FFS Savings (In the Base)	($1,206,125)	$0	($1,206,125)	$0
Delay 1 Checkwrite (In the Base)	$80,284	$40,142	$40,142	$0
CCI-Transfer of IHSS Costs to DHCS (PC 197)	$0	($1,206,125)	$0	$1,206,125
CCI-Transfer of IHSS Costs to CDSS (PC 123)	$2,496,678	$0	$0	$2,496,678
CCI-Administrative Costs (OA 19)	$8,086	$2,551	$5,535	$0
Total of CCI PCs including pass through	$3,777,633	$35,923	$38,907	$3,702,803

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:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1329

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$259,019,000	$198,348,000
- STATE FUNDS	$129,509,500	$99,174,000
PAYMENT LAG	0.9917	0.9815
% REFLECTED IN BASE	34.17 %	3.22 %
APPLIED TO BASE		
TOTAL FUNDS	$169,097,000	$188,409,900
STATE FUNDS	$84,548,480	$94,204,960
FEDERAL FUNDS	$84,548,480	$94,204,960

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) according to the Prospective Payment System (PPS). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (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 2009-10 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 2010-11 in FY 2013-14 and for FY 2011-12 in FY 2014-15. Interim rates will be adjusted to the FY 2010-11 audited levels beginning in FY 2013-14, and to the FY 2011-12 audited levels in FY 2014-15.

Currently, there are 773 active FQHCs, 274 active RHCs and 29 active CBRCs.

Reason for Change from Prior Estimate:
LA CBRC rate increases were adjusted for FYs 2013-14 and 2014-15.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 144

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.

2. A $77,000,000 FQHC retroactive rate adjustment was paid in August 2013, subsequent to old claims dating back to January 2006.

3. The FY 2013-14 LA CBRC reconciliation is based on the settlement of 91.2% of 2010 reported settlements, while the FY 2014-15 reconciliation is based on settlement of 95% of the 2011 reported settlements. Based on reported costs for fiscal years 2007-2012, reconciliations are expected to increase by 5.13% thereafter.

   Hospital closures and/or ancillary facilities no longer utilizing the hospitals' PPS rate may have attributed to the LA CBRC reconciliation decrease between FY 2013-14 and FY 2014-15.

4. The July 1, 2013 CBRC rate increase of $14,792,000 is based on the 2009 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2011-12. The estimated payment 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.

5. The July 1, 2014 CBRC rate increase of $24,420,000 is based on the 2010 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2012-13. 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.

(Dollars in Thousands)

	FY 2013-14	FY 2014-15
FQHCs Reconciliation	$81,390	$89,288
RHCs Reconciliation	$4,883	$9,530
FQHC Retroactive Rate Adjustment	$77,000	
LA CBRCs Reconciliation	$80,954	$60,318
July 2013 LA CBRC Rate Increase	$14,792	$14,792
July 2014 LA CBRC Rate Increase		$24,420
Total	**$259,019**	**$198,348**

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:	4/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1508

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$13,841,000	$139,526,000
- STATE FUNDS	$6,920,500	$69,763,000
PAYMENT LAG	0.3669	0.8982
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,078,300	$125,322,300
STATE FUNDS	$2,539,130	$62,661,130
FEDERAL FUNDS	$2,539,130	$62,661,130

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 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 145

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) 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.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payments program (QASP) for freestanding nursing facilities (NF-Bs). The QASP will be tied to demonstrated quality of care improvements and paid through the Skilled Nursing Facility Quality and Accountability Special Fund. The 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.

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

- Delay in rate increase implementation date for rate year 2013-14 from February 1, 2014 to April 1, 2014.
- Projected delay in retroactive payments for rate year 2013-14 from February 1, 2014 to September 1, 2014.
- 1% rate increase set-aside for QASP is now budgeted in the Quality and Accountability Supplemental Payments policy change.
- Managed care costs for rate year 2014-15 were included in FY 2014-15 managed care capitation rates.

Methodology:

1. The amounts reflected below are based upon rate year beginning August 1, 2013.

2. For rate year 2013-14, implementation date for rate increase will be April 1, 2014.

3. Retroactive payments for rate year 2013-14, from August 1, 2013 through March 30, 2014, will be made in September, 2014.

4. For rate year 2014-15, implementation date for rate increase will be August 1, 2014.

5. AB 1489 applied a 3% rate increase for the 2013-14 and 2014-15 rate years.

6. The General Fund amount shown here is equal to the QAF revenue deposited in the State's General Fund, on an accrual basis.

7. The estimated rate adjustment impact for rate years 2013-14 and 2014-15 is already included in the managed care FY 2013-14 and FY 2014-15 capitation rates.

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 145

(Dollars In Thousands)

FY 2013-14	TF	GF	FFP
FFS	$13,841	$6,921	$6,921
Managed Care	$0	$0	$0
Total*	**$13,841**	**$6,921**	**$6,921**

FY 2014-15	TF	GF	FFP
FFS	$105,091	$52,546	$52,546
Managed Care	$0	$0	$0
Retroactive Payments-FFS	$34,435	$17,218	$17,218
Retroactive Payments-Managed Care	$0	$0	$0
Total*	**$139,526**	**$69,763**	**$69,763**

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

*Amounts may differ due to rounding.

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	4/2014
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1563

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$45,489,000	$90,068,000
- STATE FUNDS	$22,744,500	$45,034,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$45,489,000	$90,068,000
STATE FUNDS	$22,744,500	$45,034,000
FEDERAL FUNDS	$22,744,500	$45,034,000

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:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

2. The estimated incoming funds for the Special Fund are:

	FY 2013-14	FY 2014-15
Penalties on Nursing Facilities	$995,000	$600,000
1% Weighted Average Rate Increase	$21,268,000	$43,175,000
PLI savings	$5,692,000	$5,692,000

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments will be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.

4. Estimated CDPH administrative costs are $5,560,000 TF ($2,780,000 Special Fund) in FY 2013-14 and $5,066,000 TF ($2,533,000 Special Fund) in FY 2014-15.

5. Supplemental payments are estimated to be $45,489,000 TF ($22,744,500 Special Fund) in FY 2013-14 and $90,068,000 TF ($45,034,000 Special Fund) in FY 2014-15.

(Dollars In Thousands)

	TF	GF	SF	FF
FY 2013-14				
Supplemental Payments***	$45,489	$0	$22,744	$22,744
Transfer from GF* to Special Fund**	$0	$26,960	($26,960)	$0
Total	**$45,489**	**$26,960**	**($4,216)**	**$22,744**
FY 2014-15				
Supplemental Payments***	$90,068	$0	$45,034	$45,034
Transfer from GF* to Special Fund**	$0	$48,867	($48,867)	$0
Total	**$90,068**	**$48,867**	**($3,833)**	**$45,034**

Funding:

100% GF (4260-605-0001)*
SNF Quality & Accountability (less funded by GF) (4260-698-3167)**
SNF Quality & Accountability (4260-605-3167)***
Title XIX FFP (4260-101-0890)***

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	11/2012
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1612

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$22,000,000	$30,000,000
- STATE FUNDS	$11,000,000	$15,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,000,000	$30,000,000
STATE FUNDS	$11,000,000	$15,000,000
FEDERAL FUNDS	$11,000,000	$15,000,000

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 required 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 Medi-Cal emergency medical air transportation services.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 147

Federal approval to distribute EMATA funds to emergency medical air transportation providers was obtained on November 12, 2012. In the initial phase, the Department provided supplemental payments for Medi-Cal emergency medical air 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 emergency medical air 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 February 2014 to April 2014 because of delay in expected federal approval and implementing necessary system changes, 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 medical air transportation providers. Phase I payments were made in FY 2012-13.

   $7,641,000 X 20% = $1,528,000 (GF offset)
   $7,641,000 - $1,528,000 = $6,113,000 X 2 = $12,226,000 ($6,113,000 EMATA Fund)

3. Phase II: Payment Augmentations
   Payment augmentations for Medi-Cal emergency medical air 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 medical air 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 emergency medical air transportation services.

4. Retroactive augmentation payments for FY 2012-13 will be made in April 2014.

5. Augmentation payments for FY 2013-14 will be made in August 2014.

6. Augmentation payments for FY 2014-15 will be made monthly beginning November 2014 for services period from July 2014 through February 2015. Payments for service period from March 2015 through June 2015 will be made in FY 2015-16.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 147

7. The estimated EMATA funds for Phase II on an accrual basis are:

	EMATA Fund	GF Offset (20%)	Available for Rate Augmentation
FY 2012-13	$13,750,000	$2,750,000	$11,000,000
FY 2013-14	$11,250,000	$2,250,000	$9,000,000
FY 2014-15	$11,250,000	$2,250,000	$9,000,000

8. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**EMATA**	**FFP**
GF Offset	$0	($2,750)	$2,750	
Fee For Services	$11,220		$5,610	$5,610
Managed Care	$10,780		$5,390	$5,390
Total	**$22,000**	**($2,750)**	**$13,750**	**$11,000**
FY 2014-15				
GF Offset	$0	($3,750)	$3,750	
Fee For Services	$15,000		$7,500	$7,500
Managed Care	$15,000		$7,500	$7,500
Total	**$30,000**	**($3,750)**	**$18,750**	**$15,000**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
EMATA Fund (4260-101-3168)

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	148
IMPLEMENTATION DATE:	8/2007
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1046

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$15,303,000	$25,083,000
- STATE FUNDS	$7,651,500	$12,541,500
PAYMENT LAG	0.8764	0.9263
% REFLECTED IN BASE	42.52 %	23.81 %
APPLIED TO BASE		
TOTAL FUNDS	$7,709,000	$17,702,300
STATE FUNDS	$3,854,480	$8,851,140
FEDERAL FUNDS	$3,854,480	$8,851,140

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. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% reduction and rate freeze at the 2008-2009 rate level, required by AB 97, with respect to DP/NF-Bs. On December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction.

On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunctions. The Department will implement the AB 97 payment reduction and rate freeze retroactive to June 1, 2011. Due to access concern, on December 20, 2013, CMS approved the Department's request 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.

The Department also received CMS approval not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its access and utilization analyses.

Reason for Change from Prior Estimate:

- Delay in implementation due to pending SPA approvals and additional workload for the Fiscal Intermediary.
- Effective date of new reimbursement rate methodology for ICF/DD, ICF/DD-H, and ICF/DD-N facilities changes from August 2012 to May 2014.
- Updated rate information.
- Managed care rate increase for FY 2014-15 is included in the managed care FY 2014-15 capitation rate.

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, except for DP Adult Subacute where it will take three years to be reflected in their 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 rate freeze and 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 13-14 rate using the new rate methodology in June 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 RY 2013-14 will be $0.51 for DP Subacute providers. This add-on amount will remain the same for provides impacted by the rate freeze for RYs 2013-14 and 2014-15.

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. The add-on amount for RY 2013-14 will be $0.25 for DP Subacute providers. This add-on amount will remain in effect RYs 2013-14 and FY 2014-15 for providers impacted by the rate freeze. The ICF/DD-H and ICF/DD-N facilities receiving the frozen 08-09 rates 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 through $0.22 add-on to the rate to reimburse facilities is in effect for RY 2013-14 and remains the same for RY 2014-15 for providers impacted by the rate freeze.

11. AB 1835 (Chapter 230, Statutes of 2006) required an increase in the minimum wage in California. The add-on was applied to the rate, effective August 1, 2008. Due to the new rate methodology for ICF/DD provider types, the minimum wage is not captured in the frozen 2008-09 rate. An add-on from $0.18 through $0.25 to the rates to reimburse the facilities for the additional costs will be effective for RYs 2013-14 and 2014-15 for providers receiving the frozen 2008-09 rates.

12. 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 from $0.11 through $0.19 to the rates to reimburse Freestanding and DP providers for the additional costs is effective for RY 2013-14 and will remain the same for RY 2014-15 for the providers impacted by the rate freeze.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 148

13. The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on from $0.11 through $0.32 to the rate to reimburse facilities will be effective for the RYs 2013-14 and 2014-15. However, the add-on amount for RY 2014-15 will decrease to $0.11 through $0.15 for providers not impacted by the rate freeze.

14. 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 from $0.02 through $0.03 to the rates to reimburse the facilities for the additional costs is effective for RY 2013-14 and will remain the same for RY 2014-15 for providers impacted by the rate freeze excluding ICF/DD providers.

15. 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 RY 2013-14 and will remain the same for RY 2014-15 for providers impacted by the rate freeze.

16. 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 RY 2013-14 and $0.07 for RY 2014-15.

17. 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 RY 2013-14 rate year and will remain the same for RY 2014-15 excluding ICF/DD providers.

18. 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 RYs 2013-14 and 2014-15 excluding ICF/DD-H and ICF/DD-N facilities.

19. AB 10 (Chapter 351, Statutes of 2013) increase the minimum wage, after July 1, 2014 to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour. The current minimum wage is $8.00 per hour. An add-on of $0.60 will be applied to the rate to reimburse the facilities for the additional cost beginning RY 2014-15.

20. The estimated costs of managed care rate increase for FY 2013-14 and FY 2014-15 are already included in the managed care FY 2013-14 and FY 2014-15 capitation rates.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 148

(Dollars in Thousands) **Fee-for-Service**	**FY 2013-14**	**FY 2014-15**
12-13 Rate Adjustment	$5,896	$6,502
13-14 Rate Adjustment	$955	$2,617
Retro Rate Adjustment	$3,308	$0
MDS 3.0	$131	$26
Vaccine	$569	$114
Informed Consent	$85	$17
FUTA	$504	$101
Std Adm Agreement	$16	$3
Elder Justice Act	$49	$10
Adult Day Holiday	$197	$39
Minimum Wage	$214	$43
New - ACA Reinsurance Fee & PCORI	$64	$13
New - ACA Compliance Program	$484	$97
New - HIPPA EFT and RA	$25	$5
Retro Add-ons (13-14)	$2,806	$0
13-14 Rate Adjustment		($3,280)
14-15 Rate Adjustment		$8,173
Retro Rate Adjustment		$3,475
MDS 3.0		$109
Vaccine		$1,164
Informed Consent		$60
FUTA		$994
Std Adm Agreement		$15
Elder Justice Act		$97
Adult Day Holiday		$434
Minimum Wage		$470
New - ACA Reinsurance Fee & PCORI		$237
New - ACA Compliance Program		$1,064
New - HIPPA EFT and RA		$56
New - Minimum Wage (July 2014)		$2,428
Total FFS	$15,303	$25,083
Managed care	$0	$0
Total Cost	**$15,303**	**$25,083**

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:	Davonna McClendon
FISCAL REFERENCE NUMBER:	88

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$17,239,000	$20,623,000
- STATE FUNDS	$8,619,500	$10,311,500
PAYMENT LAG	0.9021	0.9167
% REFLECTED IN BASE	54.15 %	27.21 %
APPLIED TO BASE		
TOTAL FUNDS	$7,130,300	$13,761,000
STATE FUNDS	$3,565,140	$6,880,510
FEDERAL FUNDS	$3,565,140	$6,880,510

DESCRIPTION

Purpose:
This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

Authority:
Section 1833 of the Social Security Act

Interdependent Policy Changes:
Not Applicable

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the MEI and is effective October 1st of each year.

Reason for Change from Prior Estimate:
Updated utilization data for FY 2011-12 was used to project subsequent MEI rates and estimated annual payments.

Methodology:
1. Assume utilization will increase 3.48% (rounded) in year 2013 and 0.41% (rounded) in year 2014. Utilization is based on the average percent increase of visits over the preceding three years.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 149

2. Apply the utilization factors to the actual 2012 visits.

2012 Visits		**2013 Visits**
10,179,009	3.48%	10,533,509

2013 Visits		**2014 Visits**
10,533,509	0.41%	10,577,023

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 years 2013 and 2014 is 0.8%. Therefore, the rates are:

	Rate without MEI	Rate with MEI
2013	$138.29	$138.29 x (1+0.6%) = $139.12
2014	$139.12	$139.12 x (1+0.8%) = $140.23
2015	$140.23	$140.23 x (1+0.8%) = $141.36

4. The estimated expenditures are the estimated rate multiplied the estimated visits. The annual expenditures due to MEI increase are:

(Dollars in thousands)

	Expenditures without MEI	Expenditures with MEI	MEI Increase
2012	$1,407,673	$1,416,119	$8,446
2013	$1,465,438	$1,477,162	$11,724
2014	$1,483,264	$1,495,130	$11,866

5. For FY 2013-14, the total MEI increase includes an annualized MEI increase for year 2012 of $8,446,000 and nine months of year 2013 MEI increase of $8,793,000.

6. For FY 2014-15, the total MEI increase includes an annualized MEI increase for year 2013 of $11,724,000 and nine months of year 2014 MEI increase of $8,900,000.

(Dollars in thousands)

FY 2013-14	**TF**	**GF**
2012 MEI Increase	$8,446	$4,223
2013 MEI Increase	$8,793	$4,397
Total	**$17,239**	**$8,620**
FY 2014-15		
2013 MEI Increase	$11,724	$5,862
2014 MEI Increase	$8,900	$4,450
Total	**$20,624**	**$10,312**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$5,732,000	$12,545,000
- STATE FUNDS	$2,866,000	$6,272,500
PAYMENT LAG	0.7783	0.8877
% REFLECTED IN BASE	58.69 %	28.99 %
APPLIED TO BASE		
TOTAL FUNDS	$1,842,900	$7,907,800
STATE FUNDS	$921,460	$3,953,910
FEDERAL FUNDS	$921,460	$3,953,910

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 and payment reductions for long-term care facilities (LTCs), effective June 1, 2011. The Department removed the rate freeze for certain LTCs.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 150

Subsequently, SB 239 (Chapter 657, Statutes of 2013) required the Department to remove the DP/NF-B providers from the rate freeze and payment reductions on a prospective basis. Hospice room and board rates will increase based on the nursing facility rate increases.

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

Methodology:

1. The estimated weighted increase for hospice service rates for FY 2013-14 and FY 2014-15 are 2.53% and 2.33% respectively.

2. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

   The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on Nursing Facility Level A and Distinct Part (DP) Nursing Facility Level B, and Freestanding Pediatric Subacute rates.

   Effective August 1, 2012, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

   SB 239 (Chapter 657, Statutes of 2013) required the Department to remove prospectively the DP/NF-B providers from the rate freeze and payment reductions. 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%.

	FY 2013-14	FY 2014-15
FY 2013-14 - Hospice Services	$868,000	$2,084,000
FY 2013-14 - Room & Board	$4,168,000	$4,547,000
FY 2013-14 - Retroactive Payments	$695,000	
FY 2014-15 - Hospice Services		$1,575,000
FY 2014-15 - Room & Board		$4,339,000
TOTAL*	**$5,732,000**	**$12,545,000**

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

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

DESCRIPTION

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund (GF).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)

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

Background:
AB 1762 (Chapter 230, Statutes of 2003) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. The following LTC providers are subject to a QA fee.

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA fees collected will be deposited into the fund, rather than the state General Fund, which will be used for LTC provider reimbursement rate expenditures.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 151

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

Methodology:
1. Based on three years of LTC QA fee collection data, the average annual LTC QA fee revenue on a cash basis is $439,445,000 and the average growth rate is 7.04%.

   Estimated QA fee revenue collected in FY 2014-15 is:
   $439,445,000 x (1+7.04%) = **$470,374,000**

(In Thousands)

	TF	GF	LTCQAF
FY 2013-14	**$0**	**($439,445)**	**$439,445**
FY 2014-15	**$0**	**($470,374)**	**$470,374**

Funding:
Long Term Care Quality Assurance Fund (4260-101-3213)
100% General Fund (4260-101-0001)

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	11/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1597

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$30,000	-$26,302,000
- STATE FUNDS	-$15,000	-$13,151,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	48.71 %	0.05 %
APPLIED TO BASE		
TOTAL FUNDS	-$15,400	-$26,288,800
STATE FUNDS	-$7,690	-$13,144,420
FEDERAL FUNDS	-$7,690	-$13,144,420

DESCRIPTION

Purpose:
This policy change estimates the savings due to the rate being frozen at 2008-09 levels for Distinct Part/Nursing Facility-Level B (DP/NF-B) and Rural Swing Bed rates.

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.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 152

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 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 received CMS approval not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on their access and utilization analyses.

On December 20, 2013, the Department received CMS approval 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 rates 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 rates as required by AB 97, effective October 1, 2013.

Reason for Change from Prior Estimate:
The changes are due to updated rate reimbursement amounts.

Methodology:

1. The effective date of AB 97 rate freeze is June 1, 2011.

2. **Rural Swing Bed rates**: Effective July 22, 2013, Rural Swing Bed rates are paid at the 2008-09 level rate. Prior to this, the providers received the unfrozen 2010-11 level rate. Assume the Department will recover rate freeze retroactive savings over 24 months beginning November 2013. The savings will be from August 1, 2011, through July 21, 2013.

3. **DP/NF-B facilities:** They are currently being paid at the 2011-12 level. 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 July 2014 over 66 months.

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

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	7/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1185

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$4,485,000
- STATE FUNDS	$0	-$2,242,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$4,485,000
STATE FUNDS	$0	-$2,242,500
FEDERAL FUNDS	$0	-$2,242,500

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 fourth quarter of FY 2013-14.
- Increase in monthly eligible and updated rates

Methodology:

1. Sacramento Geographic Managed Care (GMC) dental rates have changes that are retroactive to January 2013. 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 July through December 2013 are in the process of being developed.

2. Prepaid Health Plan (PHP) dental rates have changes that are retroactive to January 2013. 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 July 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 2014-15.

7. Currently, all dental plans except Liberty Dental Plan of California are being paid the January through June 2013 rates.

8. Assume the Department will receive the outstanding balances owed from the one plan in FY 2014-15.

9. There are an estimated $262,000 remaining of outstanding invoices to be collected FY 2014-15.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 153

		Existing Rate	New Rate	Change	Eligible Months	Dental Retro Rate Adjustment
GMC	Jan-Dec 2012					
	<21	$11.83	$11.46	($0.37)	1,678,001	($621,000)
	21+	$2.91	$1.45	($1.46)	912,209	($1,332,000)
PHP	Jan-Dec 2012					
	<21	$11.83	$11.46	($0.37)	2,602,403	($963,000)
	21+	$2.91	$1.45	($1.46)	895,682	($1,307,000)
Total FY 2013-14 Dental Retroactive Adjustments						($4,223,000)
Total FY 2013-14 Outstanding invoices						($262,000)
Total FY 2014-15						**($4,485,000)**
Total GF FY 2014-15						**($2,242,500)**

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

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	154
IMPLEMENTATION DATE:	9/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1703

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$12,313,000
- STATE FUNDS	$0	-$6,156,500
PAYMENT LAG	1.0000	0.8853
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$10,900,700
STATE FUNDS	$0	-$5,450,350
FEDERAL FUNDS	$0	-$5,450,350

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 April 2014 to November 2014.
- Implementation date for the 10% payment reduction has changed from November 2013 to September 2014.

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 September of 2014. 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 November 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 August 31, 2014, is estimated to be $21,342,000 TF and is expected to be recovered over 52 months beginning September 2014.

7. Savings in FY 2014-15 will consist of two months of the 10% payment reduction, eight months of the new lab rate methodology and 10 months of retroactive savings.

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**
FY 2014-15 savings	$8,208	$4,104
Retroactive Savings	$4,104	$2,052
Total*	**$12,313**	**$6,156**

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

*Amounts may differ due to rounding.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER:	155
IMPLEMENTATION DATE:	5/2012
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1579

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$2,596,000	-$30,080,000
- STATE FUNDS	-$1,298,000	-$15,040,000
PAYMENT LAG	0.6833	0.9939
% REFLECTED IN BASE	20.93 %	1.16 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,402,600	-$29,549,700
STATE FUNDS	-$701,290	-$14,774,860
FEDERAL FUNDS	-$701,290	-$14,774,860

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.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 155

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 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. 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, on December 20, 2013, CMS approved the Department's request 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:

- Delay in implementation of payment reductions and recoupment due to pending State Plan Amendment (SPA) approvals and workload issues that the litigation has created for the Fiscal Intermediary.
- Updated program expenditures.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013.

2. **FFS:** The Department implements the FFS payment reduction in various phases.
   - **AB 1629 Facilities:** This phase includes FS NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.

   - **ICF/DDs:** This phase includes ICF/DD, ICF/DD-N, and ICF/DD-H providers.

   - **DP/NF-Bs:** These are the previously enjoined providers.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 155

3. Due to access concerns, the Department will forgo the retroactive recoupment for ICF DDs.

Facility Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
ICF/DDs	6/1/2014	6/1/2014	N/A	N/A	N/A
NF-As	6/1/2011	7/1/2012	13	3/29/2013	24
		Payment Reduction Exempt Effective Date			
DP/NF-Bs					
Rural & Frontier	6/1/2011	9/1/2013	27	7/1/2014	66
Non Rural & Frontier	6/1/2011	10/1/2013	28	7/1/2014	66

4. The estimated savings due to the implementation of AB 97 payment reductions are:

		Total Fund		
		FY 2013-14	**FY 2014-15**	**Annual**
AB 1629 Facilities	FFS	$0	$0	$0
ICF/DDs	FFS	($1,087,000)	($13,048,000)	($13,048,000)
	FFS Retro	$0	$0	$0
	ICF/DDs Total	($1,087,000)	($13,048,000)	
NF-As	FFS	($254,000)	($254,000)	($254,000)
	FFS Retro	($123,000)	($92,000)	($123,000)
	NF-As Total	($377,000)	($346,000)	
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	($1,341,000)	($13,302,000)	($13,302,000)
	Total FFS Retro	($123,000)	($15,262,000)	($15,293,000)
	Total Managed Care	($1,132,000)	($1,516,000)	$ (1,516,000)
Grand Total		**($2,596,000)**	**($30,080,000)**	

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

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	7/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1505

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$35,528,000
- STATE FUNDS	$0	-$17,764,000
PAYMENT LAG	1.0000	0.9258
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$32,891,800
STATE FUNDS	$0	-$16,445,910
FEDERAL FUNDS	$0	-$16,445,910

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 changes are due to:
- Implementation date change from December 2013 to July 2014.
- Updated prospective rates resulting in a decrease in annual savings projection.

Methodology:
1. Implementation will begin in July 2014.

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%.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 156

4. Assume annual fee-for-service (FFS) savings $14,347,000.

   FFS Monthly Savings:
   $14,347,000 ÷ 12 months = $1,195,583

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 June 30, 2014, is estimated to be $28,694,000 and is expected to occur over 16.26 months beginning July 2014.

   Total recoupment of retroactive savings:
   $14,347,000 ÷ 12 months x 24 months = $28,694,000
   Monthly recoupment amount is $1,765,072

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
2014-15 Savings	($14,347)	($7,174)	($7,174)
Recoupment of Retro Savings	($21,181)	($10,590)	($10,590)
Total*	**($35,528)**	**($17,764)**	**($17,764)**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$294,788,000	-$514,522,000
- STATE FUNDS	-$147,394,000	-$257,261,000
PAYMENT LAG	0.9456	0.9971
% REFLECTED IN BASE	24.24 %	11.34 %
APPLIED TO BASE		
TOTAL FUNDS	-$211,182,200	-$454,852,300
STATE FUNDS	-$105,591,080	-$227,426,150
FEDERAL FUNDS	-$105,591,080	-$227,426,150

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157

specified providers. A recent court decision vacated the preliminary injunctions clearing the way for the Department to implement the payment reductions.

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:

- Delay in implementation due to workload issues that the litigation has created for the Fiscal Intermediary.
- Updated program expenditures.
- Additional providers and services are exempt from 10% payment reductions.

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 received CMS approval on August 28, 2013 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 stopped the 10% payment reduction in November 2013 and will refund the payment reduction for the period October 19, 2012 through October 31, 2013 in September 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 refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
     - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped 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.
     - Community-Based Adult Services (CBAS) providers located in San Francisco will be exempt from the 10% payment reduction effective July 1, 2014.

   - **Phase II**: Phase II includes all the previously enjoined providers.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157

- o Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 will be exempt from the 10% payment reduction effective August 31, 2013.
- o For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 will be exempt from the 10% payment reduction effective December 1, 2013, pending the federal approval.
- o Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions will be exempt from the 10% payment reduction effective March 31, 2012.

- **Phase III**: Phase III includes the CHDP program providers.

3. Due to access concerns, the Department will forgo the retroactive recoupments for the following providers:
   - Physicians,
   - Medical transportation,
   - Dental,
   - Clinics,
   - Certain high-cost drugs, and
   - CHDP.

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	1/10/2014	1/10/2014	N/A	N/A	N/A
Medical Transportation	9/5/2013	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	4/22/2014	63
Dental	9/5/2013	9/5/2013	N/A	N/A	N/A
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	7/1/2014	66
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 157

4. The estimated savings from AB 97 payment reduction are:

(Dollars In Thousands)		FY 2013-14	Total Fund FY 2014-15	Annual
Phase I	FFS	($38,190)	($38,700)	($44,683)
	FFS Retro	($10,382)	$0	($10,382)
	Phase I Total	($48,572)	($38,700)	
Phase II				
Physicians	FFS	($24,873)	($49,746)	($49,746)
	FFS Retro	$0	$0	$0
Medical Transportations	FFS	($12,051)	($14,461)	($14,461)
	FFS Retro	$0	$0	$0
DME/Medical Supplies	FFS	($11,596)	($17,394)	($17,394)
	FFS Retro	($1,252)	($7,510)	($7,510)
Dental	FFS	($35,419)	($60,460)	($60,460)
	FFS Retro	$0	$0	$0
Clinics	FFS	($9,256)	($18,512)	($18,512)
	FFS Retro	$0	$0	$0
Pharmacy	FFS	($47,382)	($113,718)	($113,718)
	FFS Retro	$0	($53,931)	($53,931)
	FFS	($140,577)	($274,291)	($274,291)
	FFS Retro	($1,252)	($61,441)	($61,441)
	Phase II Total	($141,829)	($335,732)	
Phase III (CHDP)	FFS	$0	($1,811)	($2,414)
	FFS Retro	$0	$0	$0
	Phase III Total	$0	($1,811)	
	FFS	($178,768)	($314,803)	($321,388)
	FFS Retro	($11,634)	($61,441)	($71,823)
	Managed Care	($104,386)	($138,278)	($138,278)
	Grand Total	**($294,788)**	**($514,522)**	

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,767,106,000	$740,311,000
- STATE FUNDS	$1,894,165,000	$416,522,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,767,106,000	$740,311,000
STATE FUNDS	$1,894,165,000	$416,522,000
FEDERAL FUNDS	$1,872,941,000	$323,789,000

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the quality assurance fee (QAF) program.

Authority:
AB 1383 (Chapter 627, Statutes of 2009)
AB 188 (Chapter 645, Statutes of 2009)
AB 1653 (Chapter 218, Statutes of 2010)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)

Interdependent Policy Changes:
PC 134 Extend Gross Premium Tax
PC 121 Extend Gross Premium Tax – Incr. Capitation Rates
PC 137 Extend Gross Premium Tax – Funding Adjustment
PC 117 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 139 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 140 MCO Tax Managed Care Plans

Background:
AB 1383 authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 158

AB 188 (Chapter 645, Statues of 2009) established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 extended the Hospital QAF program for the period January 1, 2011 through June 30, 2011 based on a modified amount of payments to hospitals and an increased amount for children's health care coverage.

SB 335 extended the Hospital QAF program from July 1, 2011 through December 31, 2013. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SB 920:

- Modified the QAF calculation and installment payment provisions, supplemental amounts paid to private hospitals for inpatient services,
- Increased the NDPH aggregate grant amounts for each fiscal year, and
- Reduced the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund (LIHP), and deleted NDPHs as recipients of money from the fund.

Reason for Change from Prior Estimate:

The changes are due to:

- Delays in managed care rate adjustments and approval,
- Delay in fee reconciliation and collections, and
- Updated data identified the availability of QAF fund for LIHP transfer.

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 2014-15.

6. $1.2 million of the QAF II program FFS payments will be paid in FY 2014-15.

7. $97.8 million of the QAF III program fees will be transferred to LIHP in FY 2014-15.

8. On a cash basis, payments to the hospitals are estimated to be:

	TF	SF(HQARF)	FF Title 19	FF Title 21	ARRA
FY 2013-14					
SB 335**	$3,767,106,000	$1,894,165,000	$1,842,141,000	$30,800,000	$0
Total	**$3,767,106,000**	**$1,894,165,000**	**$1,842,141,000**	**$30,800,000**	**$0**
FY 2014-15					
AB 1383**	$29,376,000	$11,283,000	$14,688,000	$0	$3,405,000
SB 90*	$1,216,000	$553,000	$608,000	$0	$55,000
SB 335**	$611,938,000	$306,905,000	$296,478,000	$8,555,000	$0
LIHP**	$97,781,000	$97,781,000	$0	$0	$0
Total	**$740,311,000**	**$416,522,000**	**$311,774,000**	$8,555,000	**$3,460,000**

Totals may differ due to rounding.

Funding:
Hospital Quality Assurance Revenue Fund (4260-610-3158)*
Hospital Quality Assurance Revenue Fund (4260-611-3158)**
Title XIX FFP (4260-101-0890)

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	10/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1761

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$6,945,877,000
- STATE FUNDS	$0	$3,125,877,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$6,945,877,000
STATE FUNDS	$0	$3,125,877,000
FEDERAL FUNDS	$0	$3,820,000,000

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. The Department submitted State Plan Amendments for this program on March 31, 2014.

Reason for Change from Prior Estimate:
The change is due to a delay in federal approval and updated data.

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 payment is estimated to be made in September 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 February 2015.

4. On a cash basis, the estimated QAF payments are:

(Dollars In Thousands)	TF	SF(HQARF)	FF Title 19	FF Title 21
FY 2013-14	**$0**	**$0**	**$0**	**$0**
FY 2014-15	**$6,945,877**	**$3,125,877**	**$3,794,648**	**$25,352**

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:	11/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1140

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

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:
The change is due to a delay in implementation.

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 2014.

3. Annual supplemental payments to freestanding, non-hospital based clinics are expected to total between $60,000,000 and $75,000,000.

4. Supplemental payments are paid after the completion of cost report audits.

Program payment amounts are estimated to be:

(Dollars in Thousands)

FY 2014-15	**TF**	**ARRA**	**FFP**
FY 2006-07	$60,000		$60,000
FY 2007-08	$60,000		$60,000
FY 2008-09	$63,000	$5,928	$57,072
Total FY 2014-15	**$183,000**	**$5,928**	**$177,072**

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

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	3/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1661

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$20,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$20,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$100,000,000	$20,000,000

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 updated program expenditures.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. Funding for services provided between January 30, 2010 through June 30, 2011 will be reimbursed at the appropriate FMAP rate.

3. Payments begin in March 2014.

The estimated payments on a cash basis are:

(Dollars In Thousands)

FY 2013-14		**Total FFP**	**Regular FFP**	**ARRA**	**CPE**
	FY 2009-10	$20,000	$16,000	$4,000	$32,000
	FY 2010-11	$40,000	$33,000	$7,000	$66,000
	FY 2011-12	$21,000	$21,000	$0	$42,000
	FY 2012-13	$19,000	$19,000	$0	$38,000
Total		**$100,000**	$89,000	$11,000	$178,000

FY 2014-15		**Total FFP**	**Regular FFP**	**ARRA**	**CPE**
Total	FY 2013-14	**$20,000**	$20,000	$0	$40,000

Funding:

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

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	162
IMPLEMENTATION DATE:	4/2004
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	78

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$172,138,000	$197,287,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$172,138,000	$197,287,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$172,138,000	$197,287,000

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:

- Revised caseload amounts for FY 2013-14 and FY 2014-15, and
- A delay in the FY 2002-03 Reconciliation.

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 PAYMENTS

REGULAR POLICY CHANGE NUMBER: 162

2. Payments of $172,138,000 are expected to be made in FY 2013-14 based on CPE claims for FY 2002-03 through FY 2012-13. Payments are adjusted for the change in the FMAP.

3. Payments of $178,502,000 are expected to be made in FY 2014-15 based on CPE claims. The reconciliation payments noted in Methodology #4 and 5 are not included in this amount.

4. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2014-15. Additional payments of $9,385,000 for service year 2002-03 are expected to be made in FY 2014-15 as a result of the reconciliation.

5. 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.

Estimated costs are as follows:

		FY 2013-14	
	Total FFP	**Regular FFP**	**ARRA**
FY 2002-03	$921,000	$921,000	
FY 2009-10	$929,000	$754,000	$175,000
FY 2010-11	$1,197,000	$1,002,000	$195,000
FY 2011-12	$3,032,000	$3,032,000	
FY 2012-13	$166,059,000	$166,059,000	
Total FY 2013-14	**$172,138,000**	$171,768,000	$370,000

		FY 2014-15	
	Total FFP	**Regular FFP**	**ARRA**
FY 2002-03 (Reconciliation)	$9,385,000	$9,385,000	
FY 2003-04 (Reconciliation)	$9,400,000	$9,400,000	
FY 2011-12	$830,000	$830,000	
FY 2012-13	$1,848,000	$1,848,000	
FY 2013-14	$175,824,000	$175,824,000	
Total FY 2014-15	**$197,287,000**	$197,287,000	$0

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$135,742,000	$70,000,000
- STATE FUNDS	$67,871,000	$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$135,742,000	$70,000,000
STATE FUNDS	$67,871,000	$35,000,000
FEDERAL FUNDS	$67,871,000	$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 General Fund (GF) costs of Medi-Cal children's health services.

Reason for Change from Prior Estimate:
The payments for FY 2012-13 were less than previously estimated due to the available Upper Payment Limit (UPL) room.

Methodology:
1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 163

2. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)	TF	GF**	IGT*	FF
FY 2013-14				
FY 2012-13 Payments to NDPHs	$65,742	$0	$32,871	$32,871
FY 2012-13 Children's Services	$0	($3,111)	$3,111	$0
FY 2013-14 Payments to NDPHs	$70,000	$0	$35,000	$35,000
FY 2013-14 Children's Services	$0	($3,322)	$3,322	$0
Total	**$135,742**	**($6,433)**	**$74,304**	**$67,871**
FY 2014-15				
Payments to NDPHs	$70,000	$0	$35,000	$35,000
Children's Services	$0	($3,322)	$3,322	$0
Total	**$70,000**	**($3,322)**	**$38,322**	**$35,000**

Funding:
50% Title XIX /50% Medi-Cal Inpatient Payment Adjustment Fund (4260-606-0834/4260-101-0890)*
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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$89,899,000	$46,235,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$89,899,000	$46,235,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$89,899,000	$46,235,000

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.

AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services DP-NFs Level B providers render on or after June 1, 2011.

The Department received CMS approval on December 20, 2013 to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013 for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013.

Reason for Change from Prior Estimate:
The change is due to:

- AB 97 related payments are less than initially projected,
- The addition of FY 2012-13 AB 97 related payments to be disbursed in FY 2013-14, and
- FY 2008-09 Reconciliation payments are delayed from FY 2013-14 to FY 2014-15.

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 164

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 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. Scheduled interim payments and reconciliation payments are represented below.

4. The AB 97 payment reduction/freeze will increase the uncompensated costs eligible for supplemental reimbursement under this program. The increased payments due to AB 97 payment reduction/rate freeze will be made in FY 2013-14.

5. Based on a funding of historical data and AB 97 rate reduction calculations, an estimate of $89,899,000 FFP and $46,235,000 FFP will be available in FY 2013-14 and FY 2014-15, respectively.

FY 2013-14	**Total FFP**	**FFP**	**ARRA**
FY 2006-07	$9,000	$9,000	
FY 2009-10	$4,888,000	$3,968,000	$920,000
FY 2012-13	$40,081,000	$40,081,000	
AB 97 Adjustments			
FY 2010-11	$11,453,000	$11,079,000	$374,000
FY 2011-12	$32,673,000	$32,673,000	
FY 2012-13	$795,000	$795,000	
Total FY 2013-14	**$89,899,000**	$88,605,000	$1,294,000

FY 2014-15	**Total FFP**	**FFP**	**ARRA**
FY 2008-09 Reconciliation	$2,113,000	$1,800,000	$313,000
FY 2009-10 Reconciliation	$2,398,000	$1,946,000	$452,000
FY 2013-14	$41,724,000	$41,724,000	
Total FY 2014-15	**$46,235,000**	$45,470,000	$765,000

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 164

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$120,632,000	$146,731,000
- STATE FUNDS	$50,412,000	$63,461,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$120,632,000	$146,731,000
STATE FUNDS	$50,412,000	$63,461,500
FEDERAL FUNDS	$70,220,000	$83,269,500

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) ended June 30, 2013 due to the implementation of the Diagnosis Related Group payment methodology. CMS approved State Plan Amendment (SPA) 13-011 on December 11, 2013, which maintains the Federal authority for SB 1732.

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. The Department claims federal funds using certified public expenditures from eligible DP-NFs.

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. FY 2014-15 payments increased due to bond payment schedule adjustments.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 165

Methodology:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FFP**
Hospitals	$100,824	$50,412	$50,412
DP-NFs	$19,808	$0	$19,808
Total*	**$120,632**	**$50,412**	**$70,220**

FY 2014-15	**TF**	**GF**	**FFP**
Hospitals	$126,923	$63,461	$63,462
DP-NFs	$19,808	$0	$19,808
Total	**$146,731**	**$63,461**	**$83,270**

Funding:

100% Title XIX (4260-101-0890)

50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	2/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	104

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$100,000,000	$70,000,000
- STATE FUNDS	$50,000,000	$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$100,000,000	$70,000,000
STATE FUNDS	$50,000,000	$35,000,000
FEDERAL FUNDS	$50,000,000	$35,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
This program allows Los Angeles and Alameda Counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

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

Methodology:
1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

(Dollars in Thousands)

FY 2013-14	TF	Special Deposit Fund	FFP
FY 2012-13	$30,000	$15,000	$15,000
FY 2013-14	$70,000	$35,000	$35,000
Total FY 2013-14	**$100,000**	**$50,000**	**$50,000**

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 166

(Dollars in Thousands)

FY 2014-15	TF	Special Deposit Fund	FFP
FY 2014-15	$70,000	$35,000	$35,000
Total FY 2014-15	**$70,000**	**$35,000**	**$35,000**

Funding Table:
50% Local Trauma Centers Fund / 50% Title XIX FFP (4260-601-0942142) / (4260-101-0890)

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	7/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1158

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,000,000	$15,000,000
- STATE FUNDS	$5,500,000	$7,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,000,000	$15,000,000
STATE FUNDS	$5,500,000	$7,500,000
FEDERAL FUNDS	$5,500,000	$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.

The Selective Provider Contracting Program ended in June 2013. As part of the Private Hospital Supplemental Fund, CMS approved a State Plan Amendment (SPA) on December 11, 2013 for the transition year 2013-14. A separate SPA was submitted to CMS for FY 2014-15 and after.

Reason for Change from Prior Estimate:
FY 2013-14 amounts were adjusted to reflect approved transition year SPA amounts.

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 167

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.

(Dollars In Thousands)	TF	IGT	FFP
FY 2013-14	**$11,000**	**$5,500**	**$5,500**

	TF	IGT	FFP
FY 2014-15	**$15,000**	**$7,500**	**$7,500**

Funding:

50% Reimbursement GF / 50% Title XIX (4260-610-0995 / 4260-101-0890)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	1/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1038

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

(Dollars in Thousands)

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	1/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1039

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides SRHs with increased reimbursement rates. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

(Dollars in Thousands)

	TF	FF	GF
FY 2013-14	**$8,000**	**$4,000**	**$4,000**
FY 2014-15	**$8,000**	**$4,000**	**$4,000**

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 169

Funding:
50% Title XIX FFP / 50% GF (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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$4,725,000	$3,325,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,725,000	$3,325,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,725,000	$3,325,000

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:
There is no material change.

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:

(Dollars In Thousands)

FY 2013-14	**FFP**
State Veterans' Homes for FY 2012-13	$3,100
State Veterans' Homes for FY 2013-14	$1,625
Total	**$4,725**

FY 2014-15	
State Veterans' Homes for FY 2013-14	$1,625
State Veterans' Homes for FY 2014-15	$1,700
Total	**$3,325**

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1488

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$315,564,000	$149,720,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$315,564,000	$149,720,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$315,564,000	$149,720,000

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) is implementing the SLR, a system necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive Program.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 177

System costs 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. The estimated payments for FY 2013-14 and FY 2014-15 are based on a cash-basis. The estimate for FY 2013-14 includes actual payments up to March 2014.

FY 2013-14		**FF**
4,362 professionals x $21,250 = $92,692,500	Eligibility Year 1 Professional Payments	$92,693,000
1,819 professionals x $8,500 = $15,461,500	Eligibility Year 2 Professional Payments	$15,462,000
221 professionals x $8,500 = $1,878,500	Eligibility Year 3 Professional Payments	$1,879,000
30 hospitals x $1,550,000 = $46,500,000	Eligibility Year 1 Hospital Payments	$46,500,000
163 hospitals x $930,000 = $151,590,000	Eligibility Year 2 Hospital Payments	$151,590,000
24 hospitals x $310,000 = $7,440,000	Eligibility Year 3 Hospital Payments	$7,440,000
FY 2013-14 Total		**$315,564,000**

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 177

FY 2014-15		FF
1,778 professionals x $21,250 = $37,782,500	Eligibility Year 1 Professional Payments	$37,782,500
3,149 professionals x $8,500 = $26,766,500	Eligibility Year 2 Professional Payments	$26,766,500
866 professionals x $8,500 = $7,361,000	Eligibility Year 3-4 Professional Payments	$7,361,000
0 hospitals x $1,550,000 = $0	Eligibility Year 1 Hospital Payments	$0
50 hospitals x $930,000 =$46,500,000	Eligibility Year 2 Hospital Payments	$46,500,000
101 hospitals x $310,000 = $31,310,000	Eligibility Year 3-4 Hospital Payments	$31,310,000
FY 2014-15 Total		**$149,720,000**

Funding:
100% FFP (4260-101-0001)

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	6/2011
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1232

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$120,670,000	$107,104,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$120,670,000	$107,104,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$120,670,000	$107,104,000

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 by 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)

CASH BASIS	TF	CDDS GF	FFP Regular	FFP ARRA	Total* FFP	IA #
FY 2013-14	$231,195	$110,525	$115,597	$5,073	**$120,670**	07-65896
FY 2014-15	$210,827	$103,723	$105,413	$1,691	**$107,104**	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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$72,905,000	$61,544,000
- STATE FUNDS	$36,452,500	$30,772,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$72,905,000	$61,544,000
STATE FUNDS	$36,452,500	$30,772,000
FEDERAL FUNDS	$36,452,500	$30,772,000

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) transitioned 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. Payments for noncontract hospital inpatient cost settlements made through February 2014 totaled $57.159 million TF.

2. Based upon payments made through February 2014, noncontract hospital cost settlements are estimated to total $72,905,000 in FY 2013-14 and $61,544,000 in FY 2014-15.

(Dollars in Thousands)	TF	GF	FF
FY 2013-14	**$72,905**	**$36,452**	**$36,453**
FY 2014-15	**$61,544**	**$30,772**	**$30,772**

Funding:

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

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	2/2012
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1629

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$11,972,000	$11,972,000
- STATE FUNDS	$11,972,000	$11,972,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,972,000	$11,972,000
STATE FUNDS	$11,972,000	$11,972,000
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 covered 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. Select adult optional dental services will be reinstated May 1, 2014.

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 $11,972,000 annually.

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 184

Funding:
Reimbursement GF (4260-610-0995)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	7/2010
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	1526

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$20,565,000	$16,415,000
- STATE FUNDS	$8,740,000	$6,481,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$20,565,000	$16,415,000
STATE FUNDS	$8,740,000	$6,481,000
FEDERAL FUNDS	$11,825,000	$9,934,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
The CDDS makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs, so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2013-14 and FY 2014-15. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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:
There is no change.

Methodology:
The following estimates have been provided by CDDS:

FY 2013-14* (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$3,844	$7,647	$22,981	$2,416	**$8,740**	**$11,825**

FY 2014-15* (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$1,500	$8,322	$18,116	$1,702	**$6,481**	**$9,934**

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

*Actuals may differ due to rounding.

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	6/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1826

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$3,918,000	$3,919,000
- STATE FUNDS	$1,175,000	$1,176,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,918,000	$3,919,000
STATE FUNDS	$1,175,000	$1,176,000
FEDERAL FUNDS	$2,743,000	$2,743,000

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:
The change is due to the delay in implementing the reconciliation process.

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.

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER: 186

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 the beneficiaries were American Indians.

3. The remaining $4,702,000 will be funded at a regular 50% FMAP.

4. Reconciliation payments are to be made in FY 2013-14 and FY 2014-15.

FY 2013-14	**TF**	**GF**	**FF**
FY 2008-09	$493,000	$148,000	$345,000
FY 2009-10	$998,000	$299,000	$699,000
FY 2010-11	$984,000	$295,000	$689,000
FY 2011-12	$960,000	$288,000	$672,000
FY 2012-13	$483,000	$145,000	$338,000
***Total for FY 2013-14**	**$3,918,000**	**$1,175,000**	**$2,743,000**

FY 2014-15	**TF**	**GF**	**FF**
FY 2008-09	$493,000	$148,000	$345,000
FY 2009-10	$998,000	$299,000	$699,000
FY 2010-11	$984,000	$295,000	$689,000
FY 2011-12	$960,000	$288,000	$672,000
FY 2012-13	$484,000	$146,000	$338,000
***Total for FY 2014-15**	**$3,919,000**	**$1,176,000**	**$2,743,000**

*Totals may differ due to rounding.

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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	9/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	110

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$8,247,000	$9,910,000
- STATE FUNDS	$8,247,000	$9,910,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,247,000	$9,910,000
STATE FUNDS	$8,247,000	$9,910,000
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 audits: A-09-11-02040, A-09-13-02012, A-09-13-02019, and A-09-13-02044 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 due to 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,

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187

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.

Reason for Change from Prior Estimate:
There are additional audit settlements to be paid in FY 2014-15.

Methodology:
1. The Federal audit A-09-11-02040 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-09-13-02012 identified claims within Central Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $2,953,936 FFP to CMS in FY 2014-15.

3. The Federal audit A-09-13-02019 identified claims within East Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $4,049,335 FFP to CMS in FY 2014-15.

4. The Federal audit A-09-13-02044 identified claims within Central Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $2,280,044 FFP to CMS in FY 2014-15.

5. 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.

6. The Federal audit A-09-11-02016 identified unallowable payments make for items and services furnished, ordered, or prescribed by excluded providers. The Department will return $1,030,720 FFP to CMS in FY 2013-14. Of this total amount, $1,009,300 was reimbursed to the Department in FY 2012-13 from the Department of Social Services.

7. Federal audit A-09-12-02047 identified 63 Medi-Cal claims that total's $6,961 in overpayments. The federal share is $4,040. The Department will return $4,040 FFP to CMS in FY 2013-14.

8. 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.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 187

- 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.

9. Federal audit A-09-07-00039 identified that $820,817 of claimed FFP for National Drug Code associated with manufacturers was not active in the Medicaid Drug Rebate Program during the quarter in which claims were paid. The audit also identified $584,951 of non-drug products that were misclassified in the federal CMS-64 report.

FY 2013-14		**TF**	**GF**
A-09-11-02016	Excluded Providers	$1,031,000	$1,031,000
A-09-11-02040	FPACT-Planning Services	$5,671,000	$5,671,000
A-09-12-02047	Credit Balance Review	$4,000	$4,000
A-09-07-00039	Unsupported Costs	$1,406,000	$1,406,000
	Annual Single Audits:		
A-09-09-92146	2007	$2,000	$2,000
A-09-09-94256	2008	$9,000	$9,000
A-09-10-13500	2009	$101,000	$101,000
A-09-11-15988	2010	$9,000	$9,000
A-09-12-18730	2011	$14,000	$14,000
	Total	**$8,247,000**	**$8,247,000**

FY 2014-15		**TF**	**GF**
A-09-12-02077	FPACT-Drugs Review	$627,000	$627,000
A-09-13-02012	FPACT-Services, Central Los Angeles	$2,954,000	$2,954,000
A-09-13-02019	FPACT-Services, East Los Angeles	$4,049,000	$4,049,000
A-09-13-02044	FPACT-Services, Orange County	$2,280,000	$2,280,000
	Total	**$9,910,000**	**$9,910,000**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$1,254,000	$2,180,000
- STATE FUNDS	-$9,435,500	-$9,435,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,254,000	$2,180,000
STATE FUNDS	-$9,435,500	-$9,435,500
FEDERAL FUNDS	$10,689,500	$11,615,500

DESCRIPTION

Purpose:
This policy change estimates the annual rate change posted in the Federal Register and the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to Native Americans eligible for Medi-Cal.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to Native Americans through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian Health Clinics is adjusted annually through changes posted in the *Federal Register*. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

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

Methodology:
1. Currently, there are 53 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% Title XIX FFP/ 50% GF	4260-101-0001/0890	($18,871)	($9,436)	($9,436)
100% Title XIX FFP	4260-101-0890	$20,125		$20,125
Net Impact		**$1,254**	**($9,436)**	**$10,690**

FY 2014-15:		TF	GF	FFP
50% Title XIX FFP / 50% GF	4260-101-0001/0890	($18,871)	($9,436)	($9,436)
100% Title XIX FFP	4260-101-0890	$21,051		$21,051
Net Impact		**$2,180***	**($9,436)**	**$11,615**

*Totals may differ due to rounding.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	192
IMPLEMENTATION DATE:	1/2006
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1087

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

DESCRIPTION

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2012-13 and FY 2013-14. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change also estimates the CTPS/Proposition 99 funding added by the Budget Act of 2010, which provides additional funding for Medi-Cal hospital outpatient services.

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

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 192

Methodology:

FY 2013-14	
Hospital Services Account	$58,946,000
Physicians' Services Account	$105,000
Unallocated Account	$23,540,000
Total CTPS/Prop. 99	$82,591,000
GF	($82,591,000)
Net Impact	**$0**

FY 2014-15	
Hospital Services Account	$74,137,000
Physicians' Services Account	$105,000
Unallocated Account	$25,289,000
Total CTPS/Prop. 99	$99,531,000
GF	($99,531,000)
Net Impact	**$0**

Funding:
Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	7/2005
ANALYST:	Stephanie Hockman
FISCAL REFERENCE NUMBER:	1633

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

DESCRIPTION

Purpose:
This policy change appropriates the funding for blood lead tests performed by the Medi-Cal program. It estimates the technical adjustment in funding from 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

Authority:
Health & Safety Code, Sections 105305, 105310, and 124075
Interagency Agreement (IA) #13-20109

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:
No change.

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 194

Methodology:

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.

2. The new IA with the Department of Public Health began October 29, 2013. The term of the IA will be from July 1, 2013 through June 30, 2016, and the CLPP funding allocated for FY 2013-14 and FY 2014-15 will be $714,000 for each year.

	CLPP Fund
Total FY 2013-14	**$714,000**
Total FY 2014-15	**$714,000**

Funding:

100% CLPP Fund (4260-111-0080)
100% GF (4260-101-0001)

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	4/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1621

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

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to implementation of a quality assurance fee (QAF) for hospitals from July 1, 2011 to December 31, 2013.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)

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

Background:
SB 335 establishes a hospital QAF program for the period beginning July 1, 2011 to December 31, 2013. The Centers for Medicare and Medicaid Services (CMS) approved the extension of the hospital QAF program on June 22, 2012.

AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Eliminating grant payments to DPHs in FY 2013-14, and
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 195

The grant and managed care supplemental payments are budgeted in the Hospital QAF – Hospital Payments policy change.

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

Methodology:
1. On an accrual basis, annual funds for children's health care coverage are:

(Dollars In Thousands)	Children's Health Care Coverage
FY 2012-13	$537,000
FY 2013-14	$310,000
Total	$847,000

2. On a cash basis, the estimated receipts of funds for children's health care coverage are:

(Dollars In Thousands)	TF	GF	Hosp. QA Rev Fund
FY 2012-13	$0	($134,250)	$134,250
FY 2013-14	$0	($310,000)	$310,000
FY 2013-14 Total	**$0**	**($444,250)**	**$444,250**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER:	197
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1654

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

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Social Services (CDSS) to the Department for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles, partial dual eligibles and Medi-Cal only eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to manage care health plans beginning April 1, 2014.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the California Department of Social Services (CDSS) pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population. This policy change reflects the transfer of General Fund and county funds to the Department to be used to increase managed care capitation rates. An additional policy change, Transfer of IHSS Costs to CDSS, addresses the transfer of IHSS costs from managed care rates to the Department which will in turn transfer the funds to CDSS to pay the IHSS providers. For additional information about the transfer of IHSS costs to DHCS, see policy change Transition of Dual Eligibles-Long Term Care.

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 197

Reason for Change from Prior Estimate:
There are several changes that have occurred. First, the Department has delayed the schedule for some participating counties. Second, this estimate assumes the Department's Dual-Eligible Special Needs Plans (D-SNP) policy proposal. Lastly, draft capitations assume a higher percentage of the monthly capitation is for IHSS services.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2013-14 and FY 2014-15.

(Dollars in Thousands) **FY 2013-14**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	$98,877	$49,439	$49,439	$0
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($36,593)	($18,296)	($18,296)	$0
Defer Managed Care Payment	($39,437)	($19,718)	($19,718)	$0
Total	($76,030)	($38,015)	($38,015)	$0
IHSS FFS Savings (In the Base)	($19,237)	$0	($19,237)	$0
Delay 1 Checkwrite (In the Base)	$2,463	$1,231	$1,231	$0
CCI-Transfer of IHSS Costs to DHCS	**$0**	**($19,237)**	**$0**	**$19,237**
CCI-Transfer of IHSS Costs to CDSS (PC 123)	$39,821	$0	$0	$39,821
CCI-Administrative Costs (OA 19)	$9,217	$2,759	$6,459	$0
Total of CCI PCs including pass through	$55,111	($3,823)	($123)	$59,058

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 119):				
Total Managed Care Payments	$6,901,009	$3,450,504	$3,450,504	$0
CCI-Savings and Deferral (PC 143):				
Total FFS Savings	($3,538,604)	($1,769,302)	($1,769,302)	$0
Defer Managed Care Payment	($963,695)	($481,848)	($481,848)	$0
Total	($4,502,299)	($2,251,150)	($2,251,150)	$0
IHSS FFS Savings (In the Base)	($1,206,125)	$0	($1,206,125)	$0
Delay 1 Checkwrite (In the Base)	$80,284	$40,142	$40,142	$0
CCI-Transfer of IHSS Costs to DHCS	**$0**	**($1,206,125)**	**$0**	**$1,206,125**
CCI-Transfer of IHSS Costs to CDSS (PC 123)	$2,496,678	$0	$0	$2,496,678
CCI-Administrative Costs (OA 19)	$8,086	$2,551	$5,535	$0
Total of CCI PCs including pass through	$3,777,633	$35,923	$38,907	$3,702,803

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:	7/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1760

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

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to extension of a quality assurance fee (QAF) for hospitals from January 1, 2014 to December 31, 2016.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

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

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016. The Department submitted State Plan Amendments for this program on March 31, 2014.

Reason for Change from Prior Estimate:
The changes are due to a delay in federal approval and updated data.

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: $740,000,000

   SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program. The FY 2014-15 amounts are the initial children's health care coverage funds calculation and may be adjusted based on the final reconciliation.

3. On a cash basis, the payments to health care coverage for children are:

(Dollars In Thousands)

	TF	GF	Hosp. QA Rev Fund
FY 2014-15			
FY 2013-14	$0	($310,000)	$310,000
FY 2014-15	$0	($555,000)	$555,000
Total	**$0**	**($865,000)**	**$865,000**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER:	201
IMPLEMENTATION DATE:	8/2012
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1746

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	-$218,342,000	-$212,833,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$218,342,000	-$212,833,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$218,342,000	-$212,833,000

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:
Based on updated data, savings 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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$121,306,000
- STATE FUNDS	$0	$54,587,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$121,306,000
STATE FUNDS	$0	$54,587,500
FEDERAL FUNDS	$0	$66,718,500

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases to fund the federally required Health Insurer Fee.

Authority:
The Affordable Care Act (ACA)

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

Background:
The ACA places an $8 billion fee on the health insurance industry nationwide beginning January of 2014. The fee grows to $14.3 billion in 2018 and is trended based on the rate of premium growth after 2018. The fee will be allocated to qualifying health insurers based on their market share of premium revenue in the previous year. Market share is based on commercial, Medicare, Medicaid, and State Children Health Insurance Plan (SCHIP) premium revenues. Nonprofit insurers that receive more than 80% of their premium from non-commercial business (Medicare, Medicaid and SCHIP), are exempt from the fee. The fee is not exempt from corporate income tax, therefore the cost to the plans will be compounded by the tax that must be assessed to the revenue from the additional premium to the managed care plans to account for the Health Insurer Fee.

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

5. The Internal Revenue Service will determine the effective rate and amount of tax on each plan. The total tax will be assessed on the plan's net premium.

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:	2/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1834

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$413,611,000	$1,508,167,000
- STATE FUNDS	$5,975,800	$59,423,050
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$413,611,000	$1,508,167,000
STATE FUNDS	$5,975,800	$59,423,050
FEDERAL FUNDS	$407,635,200	$1,448,743,950

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:
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, 2014, the Affordable Care Act (ACA) expands 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.

ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 206

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.

Reason for Change from Prior Estimate:
We revised the caseload projections based on actual enrollment data through February. Actual enrollment for the CalFresh adult population is occurring faster than previously estimated in November. In addition to updating the phase-in, the estimated overlap of beneficiaries in the Mandatory and Optional expansion policy changes was reduced (from an estimated 50% to 8.8%). This is also based on actual data through February.

Methodology:

1. Based upon special reports comparing Medi-Cal eligibles to other program eligibles, the following is the estimated number of enrollees who could potentially be eligible for Medi-Cal after implementation of the ACA on January 1, 2014:

a. CalFresh childless adults	580,000
b. CalFresh children	154,000
c. Parents/caretaker relatives of Medi-Cal eligible children	150,000
d. Total	884,000

2. Of those potentially eligible, it is assumed 8.8% will enroll in Medi-Cal through either the ACA mandatory expansion or the ACA optional expansion.
   884,000 potential eligibles x (100% - 8.8%) overlap = 806,208 eligibles

3. Of the remaining 806,208, it is assumed that 30% of the potential eligibles will respond and be found eligible.
   806,208 potential eligibles x 30% found eligible = 241,862 eligibles

4. Assume notifications for the Express Lane will be sent out in February 2014 for the CalFresh adult and CalFresh children populations. Assume the notifications for the CalFresh parents will be sent out in April 2014. Each population is assumed to phase-in over 5-months following the mailing of the notification.

5. Based upon the above assumptions, total member months of new eligibles will be:

Member Months	FY 2013-14	FY 2014-15
Adults	658,555	1,904,256
Children	101,123	505,613
Parents	24,624	484,272
Total	784,302	2,894,141

ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 206

6. The PMPM costs include managed care, dental and fee-for-service/other services that are not included in the managed care capitation. The average PMPM, including appropriate payment lags, is estimated to be:

PMPM	FY 2013-14	FY 2014-15
Adults	$592.06	$610.76
Children	$90.27	$97.59
Parents	$592.06	$610.76

7. CalFresh adults and 75% of the CalFresh parents are assumed to qualify for ACA enhanced federal funding. The remaining 25% of CalFresh parents are assumed to qualify for regular Title XIX 50/50% federal funding.

8. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% funding, while the rest qualify for Title XIX 50% funding.

(In thousands)	**CalFresh Adults***	**CalFresh T21 Children****	**CalFresh T19 Children*****	**CalFresh Parents*****	**TF**	**GF**
FY 2013-14	$389,904	$2,738	$6,390	$14,579	**$413,611**	**$5,976**
FY 2014-15	$1,163,049	$14,803	$34,540	$295,775	**$1,508,167**	**$59,423**

Funding:
*100% Title XIX FFP (4260-101-0890)
**Title XXI 65/35 (4260-113-0001/0890)
***Title XIX 50/50 (4260-101-0001/0890)

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER:	208
IMPLEMENTATION DATE:	7/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1832

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$17,636,000
- STATE FUNDS	$0	$8,146,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$17,636,000
STATE FUNDS	$0	$8,146,000
FEDERAL FUNDS	$0	$9,490,000

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:
Not Applicable

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:
The phase-in for administrative costs changed.

Methodology:
1. Assume the mailing campaign to beneficiaries age 0-3 will begin in July 2014.

2. Assume the mailing campaign will result in an increase of 10% in annual utilization for children age 0-3.

3. The 10% increase in the number of eligibles who are users will increase users by 77,985.

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER: 208

4. The average cost per user aged 0-5 is $272.51.

   77,985 x $272.51 = $21,252,000

5. An estimated 20% will be Title XXI Healthy Families.

   $21,252,000 x 20% = $4,250,000

6. For administrative costs, assume that there will be a 894,482 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.

   894,482 x $0.9427 = $ 843,000 ACSL
   536,792 x $0.23 = $ 123,000 Postage/mailing
   536,792 x $0.04 = $ 22,000 Printing
   $ 988,000

7. The annualized impact based upon FY 2014-15 costs is:

   $21,252,000 increased benefits + $988,000 administrative cost = $22,240,000 Total

8. Assume that reimbursement will be provided by the California First 5 Commission for the non-federal share of costs.

9. Based upon an assumed 6 month phase-in, the impact in FY 2014-15 is

FY 2014-15	TF	GF	FF
Title XIX (50/50)	$ 13,459,000	$ 6,729,500	$ 6,729,500
Title XXI (65/35)	$ 3,365,000	$ 1,177,750	$ 2,187,250
Admin Title XIX (various)	$ 812,000	$ 239,000	$ 573,000
Total	**$ 17,636,000**	**$ 8,146,250**	**$ 9,489,750**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$33,145,000
- STATE FUNDS	$0	-$16,572,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$33,145,000
STATE FUNDS	$0	-$16,572,500
FEDERAL FUNDS	$0	-$16,572,500

DESCRIPTION

Purpose:
This policy change estimates the savings from current pregnant women with incomes between 109% and 208% 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) expands 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 between 109% and 208% of the FPL are eligible for Medi-Cal pregnancy-only fee-for-service (FFS) coverage and coverage under Covered California. 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:
There is no change.

Methodology:

1) Beginning January 1, 2015, the Department estimates 8,100 beneficiaries currently receiving pregnancy only coverage will shift into Covered California. The Department will implement a wraparound of potential differences in benefits and out-of-pocket expenditures related to shifting to Covered California.

2) The total estimated savings in FY 2014-15 is:

(in thousands)	TF	GF	FF
FY 2014-15 savings	**($33,145)**	**($16,573)**	**($16,572)**

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

MCO SUPPLEMENTAL DRUG REBATE

REGULAR POLICY CHANGE NUMBER:	211
IMPLEMENTATION DATE:	4/2015
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1836

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	-$65,000,000
- STATE FUNDS	$0	-$32,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$65,000,000
STATE FUNDS	$0	-$32,500,000
FEDERAL FUNDS	$0	-$32,500,000

DESCRIPTION

Purpose:
This policy change estimates revenues collected from Managed Care Organization (MCO) Supplemental Drug rebates.

Authority:
Proposed legislation

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:
There is no change.

Methodology:
1. Projected rebates are estimated based on Medi-Cal FFS rebate data for drug utilization and expenditures.

2. Assume supplemental drug rebate alignment for all non-FFS Medi-Cal programs will provide rebate program efficiencies similar to FFS program.

MCO SUPPLEMENTAL DRUG REBATE

REGULAR POLICY CHANGE NUMBER: 211

3. Assume 6% in the aggregate will be collected in supplemental rebates for non-FFS Medi-Cal programs based on all managed care projected pharmacy expenditures of $1.3 billion (FY 2012-13).

4. Assume an additional 4% efficiency gain based on drug contracting opportunities created by single statewide drug formulary for all Medi-Cal programs.

5. Annual projected estimate of $130 million TF ($65 million GF) managed care supplemental drug rebates.

6. Rebates are invoiced quarterly. Assume invoicing will begin no later than March 31, 2015.

7. Invoice cycle lag in FY 2014-15 limits collection to two full invoice cycles and one partial cycle.

8. Assume manufacturers' rebate contracts are amended and authorized retroactive to July 1, 2014.

9. Assume managed care plan contracts are amended and authorized retroactive to July 1, 2014.

10. Assume additional system changes to Rebate Accounting Information and Claims Procesing Systems are not required.

(Dollars in Thousands)

	TF	GF	FF
FY 2014-15	**($65,000)**	**($32,500)**	**($32,500)**

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

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$126,172,000
- STATE FUNDS	$0	$56,396,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$126,172,000
STATE FUNDS	$0	$56,396,000
FEDERAL FUNDS	$0	$69,776,000

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:
MRMIB provided updated estimated costs for FY 2014-15.

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.

AIM LINKED MOTHERS 200-300% FPL

REGULAR POLICY CHANGE NUMBER: 212

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

(Dollars in Thousands)

	TF	SF	FF
FY 2014-15	**$126,172**	**$56,396**	**$69,776**

Funding:
Perinatal Insurance Fund (4260-602-0309)
Title XXI FFP (4260-113-0890)

GENETIC DISEASE SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	214
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1841

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$7,619,000
- STATE FUNDS	$0	$3,809,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$7,619,000
STATE FUNDS	$0	$3,809,500
FEDERAL FUNDS	$0	$3,809,500

DESCRIPTION

Purpose:
This policy change estimates the payment to California Department of Public Health (CDPH) for costs associated with a fee increase for prenatal screening provided to Medi-Cal beneficiaries under the Genetic Disease Screening Program (GDSP).

Authority:
Health & Safety Code Section 124977

Interdependent Policy Changes:
Not Applicable

Background:
CDPH administers California's GDSP, which includes the Prenatal Screening (PNS) Program and the Newborn Screening (NBS) Program. These programs screen for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling and confirmatory testing, including ultrasound and diagnostic procedures.

Effective July 1, 2014, GDSP will implement a $45 fee increase for their prenatal screening program. This increase is in accordance with Health & Safety Code Section 124977, which requires that the amount of the fee shall be periodically adjusted to fully supported the program.

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

Methodology:
1. Effective July 1, 2014, GDSP will implement a $45 fee increase for the prenatal screening program.

2. The Department estimates 376,249 women will have prenatal screening in FY 2014-15.

GENETIC DISEASE SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 214

Approximately 45% of them are Medi-Cal beneficiaries.

FY 2014-15: 376,249 x 45% x $45 = $7,619,000 TF ($3,809,500 GF) Rounded

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

(in thousands)	TF	GF	FF
FY 2014-15	**$7,619**	**$3,810**	**$3,810**

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

HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

REGULAR POLICY CHANGE NUMBER:	216
IMPLEMENTATION DATE:	7/2014
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	1843

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$209,000
- STATE FUNDS	$0	$104,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$209,000
STATE FUNDS	$0	$104,500
FEDERAL FUNDS	$0	$104,500

DESCRIPTION

Purpose:
This policy change estimates the costs associated with increasing rates for Homemaker Services provided under the AIDS Medi-Cal Waiver.

Authority:
AB 10 (Chapter 351, Statutes of 2013)
Section 1182.12 of the Labor Code

Interdependent Policy Changes:
Not Applicable

Background:
Local agencies, under contract with the California Department of Public Health's Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization. Homemaker services are a benefit provided to eligible clients under the AIDS Medi-Cal Waiver.

Homemaker services consist of general household activities performed when an individual who would otherwise be responsible for these activities is temporarily absent or unable to manage the home, care for themselves or others in the home. These services allow AIDS Medi-Cal Waiver participants, whose level of need is greater than others who receive only State Plan attendant services, to continue to live in an independent setting. Services rendered are in addition to, not in place of, services authorized under In-Home Supportive Services.

Reimbursement rates for homemaker services under the AIDS Medi-Cal Waiver have not increased since 2008. Subsequently, pursuant to AB 10 (Chapter 351, Statutes of 2013), the minimum wage will be increased to $9.00 per hour effective July 1, 2014. The current minimum wage is $8.00 per hour.

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

HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

REGULAR POLICY CHANGE NUMBER: 216

Methodology:

1. Assume 794 beneficiaries use Homemaker Services through the AIDS Medi-Cal Waiver.
2. Assume the new rate will increase $1.25 per hour, or $0.3125 per 15 minute unit.

   $1.00 (minimum wage increase) + $0.25 (fringe benefits) = $1.25
3. Assume the average utilization per beneficiary is 841 units.
4. Assume total costs for the rate increase will be $209,000 (rounded) in FY 2014-15.

794 beneficiaries x 841 units x $0.3125 rate per unit = $208,673 TF

Funding:

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

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER:	217
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1845

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$2,303,000	-$17,742,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$2,303,000	-$17,742,000
FEDERAL FUNDS	$2,303,000	$17,742,000

DESCRIPTION

Purpose:
This policy change estimates the savings from receiving enhanced Title XIX FFP instead of the standard Title XIX FFP for newly eligible Medi-Cal beneficaries who would have qualified under old Medi-Cal rules and subject to the standard Title XIX FFP.

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

Interdependent Policy Changes:
Not applicable

Background:
Effective January 1, 2014, the ACA expands 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.

Beginning in 2014, the ACA establishes an enhanced FMAP for expenditures related to the optional expansion population. Between 2014 and 2016, the federal government will be responsible for 100 percent of the optional expansion expenditures, gradually phasing down to 90 percent in 2020 and beyond.

The Department estimates select populations will naturally shift into the optional expansion at the time of enrollment, and this policy change estimates the savings related to the difference of receiving the standard Title XIX 50/50 FMAP and the enhanced ACA FMAP.

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

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 217

Methodology:

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

2. The Department estimates six select populations who were eligible prior to the ACA, that will take-up coverage as part of the ACA expansion group. They are:
   - Individuals who forego applying for disability determination because they are determined eligible for the new adult group;
   - Disabled individuals not enrolled in Medicare but need LTSS;
   - Medically needy 19 and 20 year olds without a share of cost not applying for Sneede v. Kizer;
   - Medically needy parents with a share of cost;
   - Pregnant women with incomes between 109 and 138% FPL;
   - SB 87 pending disability individuals.

3. The Department assumes for each select population only a proportion of the new enrollment beginning January 1, 2014 and thereafter, will elect to shift into the enhanced ACA group.

4. The total estimated savings in FY 2013-14 and FY 2014-15 are:

(Dollars in Thousands)	TF	GF	GF Savings
FY 2013-14	$4,606	$2,303	**($2,303)**
FY 2014-15	$35,484	$17,742	**($17,742)**

Funding:

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

VISION OUTREACH

REGULAR POLICY CHANGE NUMBER:	219
IMPLEMENTATION DATE:	1/2015
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1849

	FY 2013-14	FY 2014-15
FULL YEAR COST - TOTAL FUNDS	$0	$2,036,000
- STATE FUNDS	$0	$1,018,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,036,000
STATE FUNDS	$0	$1,018,000
FEDERAL FUNDS	$0	$1,018,000

DESCRIPTION

Purpose:
This policy change estimates the cost of pilot program in Los Angeles County to provide vision services at schools via a mobile vision service provider.

Authority:
Proposed Trailer Bill Language

Interdependent Policy Changes:
Not Applicable

Background:
The Department will implement a 3-year pilot program to increase utilization of vision services and eye glasses to children by allowing a mobile vision service provider that has an established Memorandum of Understanding with school districts within Los Angeles County to contract with the managed care health plans in Los Angeles County for the provision of these vision services at school sites. Any capitation rate adjustment for the managed care plans will be actuarially based and developed using projections of contingent events, including targeted populations who will receive these services to account for the increased utilization.

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

Methodology:

1. Assume the pilot program in Los Angeles County will begin in January 2015.

2. Assume that there will be 45,000 children screened annually.

3. Assume that the average cost per child will be $90.48 for examinations, necessary lenses and frames.

VISION OUTREACH

REGULAR POLICY CHANGE NUMBER: 219

4. Annual expenditures for the anticipated increase in utilization vision exams and eye glasses are estimated to be:

   45,000 children X $90.48 per child = $4,072,000 annual cost.

5. FY 2014-15 cost is estimated to be:

   $4,072,000 annual cost X 6 months/12 months = $2,036,000 ($1,018,000 GF).

6. These estimates are based upon fee-for-service costs while the actual rates will be actuarially-based.

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

May 2014 Medi-Cal Estimate

COUNTY ADMINISTRATION FUNDING SUMMARY

(Includes Other Administration)

FY 2013-2014 ESTIMATE:	Total Funds	Federal Funds	State Funds
BASE	$1,302,683,000	$651,341,500	$651,341,500
POLICY CHANGES	$520,527,000	$424,593,950	$95,933,050
SubTotal County Admin.	***$1,823,210,000***	***$1,075,935,450***	***$747,274,550***
OTHER ADMINISTRATION	$1,459,137,000	$1,300,178,900	$158,958,100
TOTAL CURRENT YEAR	**$3,282,347,000**	**$2,376,114,350**	**$906,232,650**

FY 2014-2015 ESTIMATE:	Total Funds	Federal Funds	State Funds
BASE	$1,302,683,000	$651,341,500	$651,341,500
POLICY CHANGES	$512,851,000	$592,928,700	($80,077,700)
SubTotal County Admin.	***$1,815,534,000***	***$1,244,270,200***	***$571,263,800***
OTHER ADMINISTRATION	$1,908,896,000	$1,722,820,250	$186,075,750
TOTAL BUDGET YEAR	**$3,724,430,000**	**$2,967,090,450**	**$757,339,550**

Note:

C/Y Title XXI (Item 113) activities	**$105,759,000**	**$73,247,000**	**$32,512,000**
B/Y Title XXI (Item 113) activities	**$102,221,000**	**$71,190,000**	**$31,031,000**
C/Y HIPAA (Item 117) activities	**$3,940,000**	**$3,318,000**	**$622,000**
B/Y HIPAA (Item 117) activities	**$6,267,000**	**$5,063,000**	**$1,204,000**

Fiscal Forecasting and
Data Management Branch

5/6/2014

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE SUMMARY
FISCAL YEAR 2013-14

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES PROCEDURAL	ONE-TIME CHANGES CASELOAD	ON-GOING CHANGES PROCEDURAL	ON-GOING CHANGES CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION BASE	$0	$0	$1,302,683,000	$0	$1,302,683,000	
2	SAWS	$175,602,000	$0	$0	$0		
3	IMPLEMENTATION OF ACA	$57,134,000	$0	$0	$182,866,000		
4	CalWORKS APPLICATIONS	$0	$0	$64,896,000	$0		
5	TRANSITION OF HFP TO MEDI-CAL	$0	$0	$0	$52,083,000		
7	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$26,037,000		
8	STATE-ONLY FORMER FOSTER CARE PROGRAM	$55,000	$0	$0	$0		
11	SAVE	$0	$0	$0	$0		
13	PRIOR YEAR RECONCILIATIONS	-$38,146,000	$0	$0	$0		
14	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0		
	OTHER SUBTOTAL	**$194,645,000**	**$0**	**$1,367,579,000**	**$260,986,000**	**$1,823,21**	
	GRAND TOTAL	**$194,645,000**	**$0**	**$1,367,579,000**	**$260,986,000**	**$1,823,210,0**	

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE SUMMARY
FISCAL YEAR 2014-15

		ONE-TIME CHANGES		ON-GOING CHANGES			
NO.	POLICY CHANGE TITLE	PROCEDURAL	CASELOAD	PROCEDURAL	CASELOAD		
	OTHER						
1	COUNTY ADMINISTRATION BASE	$0	$0	$1,302,683,000	$0		
2	SAWS	$148,953,000	$0	$0	$0		
3	IMPLEMENTATION OF ACA	$44,786,000	$0	$0	$195,214,000		
4	CalWORKS APPLICATIONS	$0	$0	$69,684,000	$0		
5	TRANSITION OF HFP TO MEDI-CAL	$0	$0	$0	$40,198,000		
7	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$15,313,000		
11	SAVE	$0	$0	$0	$0		
13	PRIOR YEAR RECONCILIATIONS	-$1,297,000	$0	$0	$0		
14	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0		
	OTHER SUBTOTAL	**$192,442,000**	**$0**	**$1,372,367,000**	**$250,725,000**		
	GRAND TOTAL	**$192,442,000**	**$0**	**$1,372,367,000**	**$250,725,000**		

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

NOV.	MAY		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION
PC #	PC #	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS
		OTHER							
1	1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$0
2	2	SAWS	$167,378,000	$7,566,000	$175,602,000	$7,566,000	$175,602,000	$7,566,000	$8,224,000
3	3	IMPLEMENTATION OF ACA	$143,845,000	$71,922,500	$143,845,000	$71,922,500	$240,000,000	$120,000,000	$96,155,000
4	4	CalWORKS APPLICATIONS	$64,896,000	$32,448,000	$64,896,000	$32,448,000	$64,896,000	$32,448,000	$0
5	5	TRANSITION OF HFP TO MEDI-CAL	$33,716,000	$11,800,600	$54,363,000	$19,027,050	$52,083,000	$18,229,050	$18,367,000
6	--	FY 2013-14 COST OF DOING BUSINESS	$30,813,000	$15,406,500	$30,813,000	$15,406,500	$0	$0	-$30,813,000
7	7	LOS ANGELES COUNTY HOSPITAL INTAKES	$20,354,000	$3,561,500	$26,037,000	$2,308,000	$26,037,000	$2,308,000	$5,683,000
8	8	STATE-ONLY FORMER FOSTER CARE PROGRAM	$99,000	$99,000	$99,000	$99,000	$55,000	$55,000	-$44,000
11	11	SAVE	$0	-$3,500,000	$0	-$3,500,000	$0	-$3,500,000	$0
13	13	PRIOR YEAR RECONCILIATIONS	-$70,000,000	-$35,000,000	-$37,678,000	-$18,839,000	-$38,146,000	-$19,073,000	$31,854,000
14	14	ENHANCED FEDERAL FUNDING	$0	$0	$0	-$124,201,000	$0	-$62,100,000	$0
		OTHER SUBTOTAL	**$1,693,784,000**	**$755,645,600**	**$1,760,660,000**	**$653,578,550**	**$1,823,210,000**	**$747,274,550**	**$129,426,000**
		COUNTY ADMINISTRATION GRAND TOTAL	**$1,693,784,000**	**$755,645,600**	**$1,760,660,000**	**$653,578,550**	**$1,823,210,000**	**$747,274,550**	**$129,426,000**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

NOV. PC#	MAY PC#	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2013 EST. FOR 2014-15 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
		OTHER				
1	1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500
2	2	SAWS	$155,135,000	$7,566,000	$148,953,000	$0
3	3	IMPLEMENTATION OF ACA	$130,086,000	$65,043,000	$240,000,000	$120,000,000
4	4	CalWORKS APPLICATIONS	$67,503,000	$33,751,500	$69,684,000	$34,842,000
5	5	TRANSITION OF HFP TO MEDI-CAL	$43,054,000	$15,068,900	$40,198,000	$14,069,300
7	7	LOS ANGELES COUNTY HOSPITAL INTAKES	$15,313,000	$3,561,500	$15,313,000	$3,561,500
9	--	FY 2014-2015 COST OF DOING BUSINESS	$20,218,000	$10,109,000	$0	$0
11	11	SAVE	$0	-$3,500,000	$0	-$3,500,000
12	--	REDUCTION TO COLA TO COUNTIES FOR FY 2014-1	-$20,218,000	-$10,109,000	$0	$0
13	13	PRIOR YEAR RECONCILIATIONS	-$35,881,000	-$17,940,500	-$1,297,000	-$648,500
14	14	ENHANCED FEDERAL FUNDING	$0	-$248,402,000	$0	-$248,402,000
		OTHER SUBTOTAL	**$1,677,893,000**	**$506,489,900**	**$1,815,534,000**	**$571,263,800**
		COUNTY ADMINISTRATION GRAND TOTAL	**$1,677,893,000**	**$506,489,900**	**$1,815,534,000**	**$571,263,800**

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

MAY PC#	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14 TOTAL FUNDS	MAY 2014 EST. FOR 2013-14 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
	OTHER				
1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500
2	SAWS	$175,602,000	$7,566,000	$148,953,000	$0
3	IMPLEMENTATION OF ACA	$240,000,000	$120,000,000	$240,000,000	$120,000,000
4	CalWORKS APPLICATIONS	$64,896,000	$32,448,000	$69,684,000	$34,842,000
5	TRANSITION OF HFP TO MEDI-CAL	$52,083,000	$18,229,050	$40,198,000	$14,069,300
7	LOS ANGELES COUNTY HOSPITAL INTAKES	$26,037,000	$2,308,000	$15,313,000	$3,561,500
8	STATE-ONLY FORMER FOSTER CARE PROGRAM	$55,000	$55,000	$0	$0
11	SAVE	$0	-$3,500,000	$0	-$3,500,000
13	PRIOR YEAR RECONCILIATIONS	-$38,146,000	-$19,073,000	-$1,297,000	-$648,500
14	ENHANCED FEDERAL FUNDING	$0	-$62,100,000	$0	-$248,402,000
	OTHER SUBTOTAL	**$1,823,210,000**	**$747,274,550**	**$1,815,534,000**	**$571,263,800**
	COUNTY ADMINISTRATION GRAND TOTAL	**$1,823,210,000**	**$747,274,550**	**$1,815,534,000**	**$571,263,800**

Costs shown do not include percent reflected in base calculation.

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

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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:

(Dollars in Thousands)

Base Allocation	TF	GF	FF
FY 2013-14	**$1,302,683**	**$651,341**	**$651,342**
FY 2014-15	**$1,302,683**	**$651,341**	**$651,342**

Funding:
50% Title XIX / 50% GF (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	$148,953,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$175,602,000	$0	$148,953,000	$0
STATE FUNDS	$7,566,000	$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.	$175,602,000	$0	$148,953,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$175,602,000	$0	$148,953,000	$0
STATE FUNDS	$7,566,000	$0	$0	$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, and Enrollment. 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:
Updated CDSS FY 2014-15 expenditures.

Methodology:

1. The cash basis estimate was provided by CDSS.

(Dollars In Thousands)	FY 2013-14	FY 2014-15
LA County LEADER M&O*	$15,132 ($7,566 GF)	$0
LEADER Replacement	$73,385	$80,968
SAWS Customer Service Center	$35,877	$8,287
SPM	$1,518	$1,643
WCDS-CalWIN	$19,984	$30,577
Consortia IV	$17,903	$27,305
State Client Index	$69	$69
CalHEERS Development	$11,132	$0
CAlHEERS Interface M&O	$419	$0
Consortium-IV Migration	$183	$104
Total	**$175,602**	**$148,953**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)*
100% 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.	$57,134,000	$0	$44,786,000	$0
CASELOAD - TOT.	$0	$182,866,000	$0	$195,214,000
TOTAL FUNDS	$57,134,000	$182,866,000	$44,786,000	$195,214,000
STATE FUNDS	$28,567,000	$91,433,000	$22,393,000	$97,607,000
% 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.	$57,134,000	$0	$44,786,000	$0
CASELOAD - TOT.	$0	$182,866,000	$0	$195,214,000
TOTAL FUNDS	$57,134,000	$182,866,000	$44,786,000	$195,214,000
STATE FUNDS	$28,567,000	$91,433,000	$22,393,000	$97,607,000

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 expands 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 are several changes from the prior estimate. First, CA-6 from the November estimate was inactivated and moved into this policy change as a line item. Second, the Department revised the caseload projections based on actual enrollment data through February and pending caseload data. These changes increased the estimated number of new applications in FY 2013-14 and decreased in FY 2014-15. Third, the Department postponed annual redeterminations for 5-months which decreased the estimated number of redeterminations in FY 2013-14 and increased in FY 2014-15. Lastly, the Department added additional one-time ACA implementation funding in both FY 2013-14 and FY 2014-15.

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. Effective January 1, 2014, the Department will postpone redeterminations for 5-months for Medi-Cal beneficiaries who will be subject to the new MAGI standard and several non-MAGI groups. This 5-month delay provides counties with additional time to process the new incoming ACA expansion beneficiaries. Beginning in June, the Department assumes counties will process two-months of annual redeterminations through October to complete the backlog.

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).

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

6. In FY 2013-14 the total estimated county administrative costs are:

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**
New Applications	$165,743	$82,871
Redeterminations	$17,124	$8,562
Training costs	$8,059	$4,030
County/Statewide Planning and Support	$5,700	$2,850
One-time FY 2013-14 Cost of Doing Business*	$30,813	$15,407
One-time ACA implementation funding	$12,562	$6,281
Total (rounded)	**$240,000**	**$120,000**

*FY 2013-14 Cost of Doing Business funding was previously a separate policy change (CA-6) in the November estimate. CA-6 has been inactivated and the one-time costs were added to this policy change as a line-item.

7. In FY 2014-15 the total estimated county administrative costs are:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**
New Applications	$58,225	$29,112
Redeterminations	$136,989	$68,495
One-time ACA implementation funding	$44,786	$22,393
Total (rounded)	**$240,000**	**$120,000**

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	$69,684,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$64,896,000	$0	$69,684,000
STATE FUNDS	$0	$32,448,000	$0	$34,842,000
% 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	$64,896,000	$0	$69,684,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$64,896,000	$0	$69,684,000
STATE FUNDS	$0	$32,448,000	$0	$34,842,000

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:
(Rounded)

	TF	GF	FF
FY 2013-14	**$64,896,000**	**$32,448,000**	**$32,448,000**
FY 2014-15	**$69,684,000**	**$34,842,000**	**$34,842,000**

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:	Randolph Alarcio
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	$52,083,000	$0	$40,198,000
TOTAL FUNDS	$0	$52,083,000	$0	$40,198,000
STATE FUNDS	$0	$18,229,050	$0	$14,069,300
% 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	$52,083,000	$0	$40,198,000
TOTAL FUNDS	$0	$52,083,000	$0	$40,198,000
STATE FUNDS	$0	$18,229,050	$0	$14,069,300

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 November 2013 Estimate, it was estimated that an average of 969,026 HFP subscribers and 994,860 HFP subscribers would transition into Medi-Cal in FY 2013-14 and FY 2014-15, respectively. Based on new actual HFP data from September 2013 through February 2014, the projected average of HFP subscribers decreased for both fiscal years.

TRANSITION OF HFP TO MEDI-CAL

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

1. Based on actual HFP data through February 2014, an average of 894,756 HFP subscribers will transition in FY 2013-14 and 919,482 HFP subscribers in FY 2014-15. This does not include 4,009 AIM infants with incomes between 251-300% FPL.

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) **FY 2013-14**	**TF**	**GF**
Ongoing Costs	$37,368	$13,079
FY 2012-13 Rollover	$14,715	$5,150
Total	**$52,083**	**$18,229**

	TF	**GF**
FY 2014-15	**$40,198**	**$14,069**

Funding:

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

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 (DPSS) eligibility workers for regular Medi-Cal intakes. The federal share for any costs not covered by the DPSS rate is passed through to the county.

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

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

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

Care Act; therefore, the Department plans to freeze the funding for FY 2013-14 at FY 2012-13 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 x $268 x 12 = $7,123,000 ($3,561,500 GF)
FY 2014-15: 2,215 x $268 x 12 = $7,123,000 ($3,561,500 GF)

2. 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.

3. 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**	**FF**	**TF**	**GF**	**FF**
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
Total	**$26,037**	**$2,308**	**$23,729**	**$15,313**	**$3,561**	**$11,752**

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.	$55,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$55,000	$0	$0	$0
STATE FUNDS	$55,000	$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.	$55,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$55,000	$0	$0	$0
STATE FUNDS	$55,000	$0	$0	$0

DESCRIPTION

Purpose:
This policy change estimates county administrative costs related to extending Medi-Cal benefits to former foster care youth who turned 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 changed 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 who turned 21 years old between July 1, 2013 and December 31, 2013 retained their Medi-Cal benefits. These costs are funded with 100% State General Fund.

Reason for Change from Prior Estimate:
Actual certified eligible caseloads between July and December 2013 were used to update the estimated costs.

STATE-ONLY FORMER FOSTER CARE PROGRAM

COUNTY ADMIN. POLICY CHANGE NUMBER: 8

Methodology:

1. The Department has extended Medi-Cal benefits to former foster youth who turned 21 years old between July 1, 2013 and December 31, 2013.

2. The Department estimates 549 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:

	TF	GF	FF
FY 2013-14	**$55,000**	**$55,000**	**$0**

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

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 2008-09*	$17,430,750
FY 2009-10*	$6,881,956
FY 2010-11*	$6,431,214
FY 2011-12*	$6,418,702
FY 2012-13**	$6,417,908

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:

	Total Fund	FF Shift
FY 2013-14	$7,000,000	**$3,500,000**
FY 2014-15	$7,000,000	**$3,500,000**

* Actual
** Preliminary

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

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.	-$38,146,000	$0	-$1,297,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	-$38,146,000	$0	-$1,297,000	$0
STATE FUNDS	-$19,073,000	$0	-$648,500	$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.	-$38,146,000	$0	-$1,297,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	-$38,146,000	$0	-$1,297,000	$0
STATE FUNDS	-$19,073,000	$0	-$648,500	$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 adjusted the FY 2012-13 interim and final reconciliation amount based upon actual collections and historical trends, respectively. Due to the ACA, the Department is not anticipating any additional savings for the final FY 2012-13 reconciliation.

Methodology:
1. 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 of the interim FY 2011-12 reconciliation in the first quarter of FY 2013-14. The total amount is $1,765,000.

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 in FY 2013-14. 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. The Department plans to collect the third installment of the FY 2012-13 interim reconciliation and the final amount in FY 2014-15. Due to the ACA, the Department is not anticipating any additional savings for the final FY 2012-13 reconciliation.

(Dollars in Thousands)

FY 2013-14	**TF**	**GF**	**FF**
FY 2012-13 Interim Reconciliation	($34,584)	($17,292)	($17,292)
FY 2011-12 Interim Reconciliation			
Third Installment Payment	($1,765)	($882)	($883)
FY 2011-12 Final Reconciliation	($1,797)	($898)	($899)
Total FY 2013-14	**($38,146)**	**($19,072)**	**($19,074)**
FY 2014-15			
FY 2012-13 Interim Reconciliation			
Third Installment Payment	**($1,297)**	**($648)**	**($649)**

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	-$62,100,000	$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	-$62,100,000	$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 was submitted to CMS for approval.

Reason for Change from Prior Estimate:
Change in the effective date for approval of the Department's APD from January 1, 2014 to April 1, 2014.

Methodology:

1. Assume an April 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-rounded)

FY 2013-14	**TF**	**GF**	**FF**
Funding at 50% FFP	$248,400	$124,200	$124,200
Funding at 75% FFP	$248,400	$62,100	$186,300
Difference	**$0**	**($62,100)**	**$62,100**
FY 2014-15			
Funding at 50% FFP	$993,608	$496,804	$496,804
Funding at 75% FFP	$993,608	$248,402	$745,206
Difference	**$0**	**($248,402)**	**$248,402**

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:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14 TOTAL FUNDS	FISCAL YEAR 2013-14 STATE FUNDS	FISCAL YEAR 2014-15 TOTAL FUNDS
	CDHS			
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$92,000,000	$0	$475,650,000
2	CCS CASE MANAGEMENT	$175,461,000	$68,665,300	$182,238,000
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$133,924,000	$0	$151,347,000
4	BTR - LIHP - ADMINISTRATIVE COSTS	$102,861,000	$0	$115,177,000
5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$43,877,000	$0	-$82,730,0
6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,300	$33,718,000
7	SMH MAA	$22,830,000	$0	$24,086,000
8	CALHEERS DEVELOPMENT	$30,603,000	$8,130,700	$128,618,000
9	ACA OUTREACH AND ENROLLMENT COUNSELORS	$26,500,000	$13,250,000	$26,500,000
10	TRANSITION OF HFP TO MEDI-CAL	$25,272,000	$8,845,200	$15,937,00
11	ARRA HITECH INCENTIVE PROGRAM	$11,206,000	$984,000	$33,725,000
12	POSTAGE & PRINTING	$18,057,000	$9,119,500	$18,832,000
13	ACA EXPANSION ADMIN COSTS	$905,000	$452,500	$1,155,000
14	COUNTY UR & QA ADMIN	$16,440,000	$0	$18,272,000
15	MIS/DSS CONTRACT	$10,900,000	$2,892,800	$12,476,000
16	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000
17	CCI-ADMINISTRATIVE COSTS	$9,217,000	$2,758,500	$8,086,000
18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITI	$8,348,000	$1,621,600	$4,816,000
19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$6,016,000	$802,600	$8,076,000
20	ADHC TRANSITION-ADMINISTRATION	$6,172,000	$3,086,000	
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,188,000	$1,715,300	$5,447,000
22	MEDI-CAL RECOVERY CONTRACTS	$5,266,000	$1,316,500	$5,721,000
23	COORDINATED CARE MANAGEMENT PILOT	$4,716,000	$2,358,000	$118,000
24	RESTORATION OF SELECT ADULT DENTAL BENEFITS	$1,778,000	$444,500	
25	PASRR	$3,176,000	$794,000	$8,590,000

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14 TOTAL FUNDS	FISCAL YEAR 2013-14 STATE FUNDS	FISCAL YEAR 2014-15 TOTAL FUNDS
	CDHS			
27	FAMILY PACT EVALUATION	$2,861,000	$1,430,500	$2,861,000
28	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	$2,835,000	$0	$2,660
29	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,400,000	$1,200,000	$2,662
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$2,488,000	$622,000	$4,815,000
31	SDMC SYSTEM M&O SUPPORT	$1,500,000	$750,000	$3,000,000
32	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000
33	BUSINESS RULES EXTRACTION	$0	$0	$2,750,000
35	MITA	$338,000	$33,800	$985,000
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,0
37	MMA - DSH ANNUAL INDEPENDENT AUDIT	$1,284,000	$642,000	$856,000
38	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000
39	MEDI-CAL INPATIENT SERVICES FOR INMATES	$560,000	$0	$560,000
40	MEDS MODERNIZATION	$546,000	$54,600	$4,533,000
41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$597,000	$298,500	$644,
42	VITAL RECORDS DATA	$90,000	$0	$836,000
44	CCT OUTREACH - ADMINISTRATIVE COSTS	$485,000	$0	$242,000
45	ETL DATA SOLUTION	$469,000	$77,900	$325,000
46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$400,000	$200,000	$240,00
47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$216,000	$54,000	$180,00
48	DENTAL PAPD PROJECT MANAGER	$240,000	$120,000	$239,000
49	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	$214,000	$107,000	
50	ANNUAL EDP AUDIT CONTRACTOR	$162,000	$81,000	$162,000
51	EPOCRATES	$107,000	$53,500	$107,000
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000
53	TAR POSTAGE	$111,000	$55,500	$115,000

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14 TOTAL FUNDS	FISCAL YEAR 2013-14 STATE FUNDS	FISCAL YEAR 2014-15 TOTAL FUNDS
	CDHS			
54	DMHC INTER-AGENCY AGREEMENT - ADMIN	$158,000	$0	$189,000
55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$62,000	$31,000	$62,000
56	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$63,000	$31,500	$59,000
57	RECOVERY AUDIT CONTRACTOR COSTS	$1,000	$500	$12,000
58	DRUG MEDI-CAL COUNTY ADMINISTRATION	$0	$0	$23,029,000
59	NEWBORN HEARING SCREENING PROGRAM	$0	$0	$4,136,000
60	RATE STUDIES FOR MAIC AND AAC VENDOR	$0	$0	$1,000,000
80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	$250,000	$125,000	
82	DENTAL FI RE-PROCUREMENT IV&V	$0	$0	$282,000
	CDHS SUBTOTAL	**$825,855,000**	**$151,994,900**	**$1,266,383,000**
	OTHER DEPARTMENTS			
61	PERSONAL CARE SERVICES	$252,272,000	$0	$264,886,000
62	HEALTH-RELATED ACTIVITIES - CDSS	$216,528,000	$0	$223,024,000
63	CDDS ADMINISTRATIVE COSTS	$39,021,000	$0	$32,240,000
64	MATERNAL AND CHILD HEALTH	$25,870,000	$0	$27,503,000
65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE	$25,143,000	$0	$25,143,000
66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$31,598,000	$0	$30,928,
67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COS	$19,012,000	$2,780,000	$17,534,000
68	CLPP CASE MANAGEMENT SERVICES	$7,400,000	$0	$5,200,000
69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	$6,832,000	$2,698,700	$6,130,000
70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,129,000	$0	$3,523,00
71	CDPH I&E PROGRAM AND EVALUATION	$1,028,000	$0	$946,000
72	CDDS DENTAL SERVICES	$1,197,000	$1,197,000	$1,197,000
73	KIT FOR NEW PARENTS	$1,017,000	$0	$1,017,000
74	QUITLINE ADMINISTRATIVE SERVICES	$1,000,000	$0	$1,000,000

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2013-14 TOTAL FUNDS	FISCAL YEAR 2013-14 STATE FUNDS	FISCAL YEAR 2014-15 TOTAL FUNDS
	OTHER DEPARTMENTS			
75	VETERANS BENEFITS	$956,000	$0	$956,000
76	CHHS AGENCY HIPAA FUNDING	$651,000	$0	$651,000
77	MERIT SYSTEM SERVICES FOR COUNTIES	$195,000	$97,500	$195,000
78	FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUTREACH	$53,000	$0	
79	PIA EYEWEAR COURIER SERVICE	$380,000	$190,000	$440,000
	OTHER DEPARTMENTS SUBTOTAL	**$633,282,000**	**$6,963,200**	**$642,513,000**
	GRAND TOTAL	**$1,459,137,000**	**$158,958,100**	**$1,908,896,000**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

NOV.	MAY		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION	
PC #	PC #	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
		CDHS								
1	1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$303,000,000	$0	$431,815,000	$0	$92,000,000	$0	-$211,000,000	
2	2	CCS CASE MANAGEMENT	$174,950,000	$67,638,500	$175,885,000	$68,086,800	$175,461,000	$68,665,300	$511,000	
3	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$141,726,000	$0	$137,795,000	$0	$133,924,000	$0	-$7,802,000	
4	4	BTR - LIHP - ADMINISTRATIVE COSTS	$742,976,000	$0	$102,861,000	$0	$102,861,000	$0	-$640,115,000	
5	5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$26,641,000	$0	$47,779,000	$0	$43,877,000	$0	$17,236,000	
6	6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,250	$33,718,000	$11,871,250	$33,718,000	$11,871,250	$0	
7	7	SMH MAA	$24,509,000	$0	$28,193,000	$0	$22,830,000	$0	-$1,679,000	
8	8	CALHEERS DEVELOPMENT	$27,134,000	$8,063,800	$27,709,000	$7,859,450	$30,603,000	$8,130,650	$3,469,000	
9	9	ACA OUTREACH AND ENROLLMENT COUNSELORS	$0	$0	$26,500,000	$13,250,000	$26,500,000	$13,250,000	$26,500,000	
10	10	TRANSITION OF HFP TO MEDI-CAL	$24,134,000	$8,446,900	$26,104,000	$9,136,400	$25,272,000	$8,845,200	$1,138,000	
11	11	ARRA HITECH INCENTIVE PROGRAM	$2,626,000	$154,000	$21,206,000	$1,984,000	$11,206,000	$984,000	$8,580,000	
12	12	POSTAGE & PRINTING	$25,427,000	$12,653,700	$19,245,000	$9,713,500	$18,057,000	$9,119,500	-$7,370,000	
13	13	ACA EXPANSION ADMIN COSTS	$19,085,000	$9,542,500	$16,825,000	$8,412,500	$905,000	$452,500	-$18,180,000	
14	14	COUNTY UR & QA ADMIN	$16,798,000	$0	$16,558,000	$0	$16,440,000	$0	-$358,000	
15	15	MIS/DSS CONTRACT	$10,900,000	$2,892,750	$10,900,000	$2,892,750	$10,900,000	$2,892,750	$0	
16	16	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	
17	17	CCI-ADMINISTRATIVE COSTS	$5,172,000	$2,542,500	$8,786,000	$2,543,000	$9,217,000	$2,758,500	$4,045,000	
18	18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TI	$3,315,000	$396,900	$7,837,000	$1,560,300	$8,348,000	$1,621,600	$5,033,000	
19	19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$6,704,000	$803,000	$6,368,000	$973,150	$6,016,000	$802,600	-$688,000	
20	20	ADHC TRANSITION-ADMINISTRATION	$656,000	$328,000	$6,172,000	$3,086,000	$6,172,000	$3,086,000	$5,516,000	
21	21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,435,000	$1,828,000	$5,631,000	$1,889,000	$5,188,000	$1,715,250	-$247,000	
22	22	MEDI-CAL RECOVERY CONTRACTS	$5,009,000	$1,252,250	$5,290,000	$1,322,500	$5,266,000	$1,316,500	$257,000	
23	23	COORDINATED CARE MANAGEMENT PILOT	$4,716,000	$2,358,000	$4,716,000	$2,358,000	$4,716,000	$2,358,000	$0	
24	24	RESTORATION OF SELECT ADULT DENTAL BENEFI	$4,255,000	$1,350,000	$905,000	$286,000	$1,778,000	$444,500	-$2,477,000	
25	25	PASRR	$3,616,000	$904,000	$3,366,000	$841,500	$3,176,000	$794,000	-$440,000	
26		ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$0	$0	$2,992,000	$1,022,000	$0	$0	$0	
27	27	FAMILY PACT EVALUATION	$2,861,000	$1,430,500	$2,861,000	$1,430,500	$2,861,000	$1,430,500	$0	
28	28	PREVENTION OF CHRONIC DISEASE GRANT PROJE	$2,500,000	$0	$2,835,000	$0	$2,835,000	$0	$335,000	
29	29	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,530,000	$1,265,000	$2,420,000	$1,210,000	$2,400,000	$1,200,000	-$130,000	
30	30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$2,000,000	$500,000	$2,016,000	$504,000	$2,488,000	$622,000	$488,000	

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

NOV.	MAY		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION	
PC #	PC #	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
		CDHS								
31	31	SDMC SYSTEM M&O SUPPORT	$1,834,000	$917,000	$1,500,000	$750,000	$1,500,000	$750,000	-$334,000	
32	32	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$1,207,000	$603,500	$0	
33		BUSINESS RULES EXTRACTION	$0	$0	$1,100,000	$550,000	$0	$0	$0	
34		MEDS INTERFACE WITH CALHEERS	$1,008,000	$852,800	$1,008,000	$852,800	$0	$0	-$1,008,000	
35	35	MITA	$0	$0	$1,000,000	$100,000	$338,000	$33,800	$338,000	
36	36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$950,000	$950,000	$0	
37	37	MMA - DSH ANNUAL INDEPENDENT AUDIT	$856,000	$428,000	$856,000	$428,000	$1,284,000	$642,000	$428,000	
38	38	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000	$750,000	$375,000	$0	
39	39	MEDI-CAL INPATIENT SERVICES FOR INMATES	$560,000	$0	$560,000	$0	$560,000	$0	$0	
40	40	MEDS MODERNIZATION	$546,000	$54,600	$546,000	$54,600	$546,000	$54,600	$0	
41	41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$572,000	$286,000	$539,000	$269,500	$597,000	$298,500	$25,000	
42	42	VITAL RECORDS DATA	$926,000	$0	$508,000	$0	$90,000	$0	-$836,000	
44	44	CCT OUTREACH - ADMINISTRATIVE COSTS	$727,000	$0	$485,000	$0	$485,000	$0	-$242,000	
45	45	ETL DATA SOLUTION	$469,000	$77,900	$469,000	$77,900	$469,000	$77,900	$0	
46	46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$400,000	$200,000	$400,000	$200,000	$400,000	$200,000	$0	
47	47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$350,000	$87,500	$350,000	$87,500	$216,000	$54,000	-$134,000	
48	48	DENTAL PAPD PROJECT MANAGER	$288,000	$144,000	$240,000	$120,000	$240,000	$120,000	-$48,000	
49	49	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	$102,000	$51,000	$214,000	$107,000	$214,000	$107,000	$112,000	
50	50	ANNUAL EDP AUDIT CONTRACTOR	$400,000	$200,000	$162,000	$81,000	$162,000	$81,000	-$238,000	
51	51	EPOCRATES	$107,000	$53,500	$107,000	$53,500	$107,000	$53,500	$0	
52	52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMEI	$100,000	$0	$100,000	$0	$100,000	$0	$0	
53	53	TAR POSTAGE	$106,000	$53,000	$99,000	$49,500	$111,000	$55,500	$5,000	
54	54	DMHC INTER-AGENCY AGREEMENT - ADMIN	$0	$0	$79,000	$0	$158,000	$0	$158,000	
55	55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$100,000	$50,000	$70,000	$35,000	$62,000	$31,000	-$38,000	
56	56	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$87,000	$43,500	$42,000	$21,000	$63,000	$31,500	-$24,000	
57	57	RECOVERY AUDIT CONTRACTOR COSTS	$9,000	$4,500	$2,000	$1,000	$1,000	$500	-$8,000	
80	80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDE	$0	$0	$250,000	$125,000	$250,000	$125,000	$250,000	
		HEALTH CARE OPTIONS CONSULTANT COSTS	$222,000	$111,000	$0	$0	$0	$0	-$222,000	
		CDHS SUBTOTAL	**$1,645,049,000**	**$146,754,350**	**$1,208,861,000**	**$163,114,400**	**$825,855,000**	**$151,994,900**	**-$819,194,000**	
		OTHER DEPARTMENTS								

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2013-14

NOV.	MAY		2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION	
PC #	PC #	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
		OTHER DEPARTMENTS								
61	61	PERSONAL CARE SERVICES	$262,751,000	$0	$262,937,000	$0	$252,272,000	$0	-$10,479,000	
62	62	HEALTH-RELATED ACTIVITIES - CDSS	$218,951,000	$0	$219,207,000	$0	$216,528,000	$0	-$2,423,000	
63	63	CDDS ADMINISTRATIVE COSTS	$33,875,000	$0	$40,187,000	$0	$39,021,000	$0	$5,146,000	
64	64	MATERNAL AND CHILD HEALTH	$34,190,000	$0	$29,169,000	$0	$25,870,000	$0	-$8,320,000	
65	65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTE	$25,143,000	$0	$25,143,000	$0	$25,143,000	$0	$0	
66	66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$24,111,000	$0	$33,229,000	$0	$31,598,000	$0	$7,487,000	
67	67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPC	$19,005,000	$2,433,000	$18,730,000	$2,780,000	$19,012,000	$2,780,000	$7,000	
68	68	CLPP CASE MANAGEMENT SERVICES	$5,200,000	$0	$7,400,000	$0	$7,400,000	$0	$2,200,000	
69	69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	$7,049,000	$2,784,400	$7,049,000	$2,784,400	$6,832,000	$2,698,700	-$217,000	
70	70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,146,000	$0	$3,072,000	$0	$3,129,000	$0	-$17,000	
71	71	CDPH I&E PROGRAM AND EVALUATION	$1,557,000	$0	$1,375,000	$0	$1,028,000	$0	-$529,000	
72	72	CDDS DENTAL SERVICES	$1,270,000	$1,270,000	$1,270,000	$1,270,000	$1,197,000	$1,197,000	-$73,000	
73	73	KIT FOR NEW PARENTS	$1,017,000	$0	$1,017,000	$0	$1,017,000	$0	$0	
74	74	QUITLINE ADMINISTRATIVE SERVICES	$2,000,000	$0	$1,000,000	$0	$1,000,000	$0	-$1,000,000	
75	75	VETERANS BENEFITS	$956,000	$0	$956,000	$0	$956,000	$0	$0	
76	76	CHHS AGENCY HIPAA FUNDING	$651,000	$0	$651,000	$0	$651,000	$0	$0	
77	77	MERIT SYSTEM SERVICES FOR COUNTIES	$184,000	$92,000	$195,000	$97,500	$195,000	$97,500	$11,000	
78	78	FPACT SUPPORT, PROVIDER EDUC. & CLIENT OUT	$27,000	$0	$53,000	$0	$53,000	$0	$26,000	
79	79	PIA EYEWEAR COURIER SERVICE	$324,000	$162,000	$324,000	$162,000	$380,000	$190,000	$56,000	
		FAMILY PACT EVALUATION	$63,000	$0	$0	$0	$0	$0	-$63,000	
		OTHER DEPARTMENTS SUBTOTAL	**$641,470,000**	**$6,741,400**	**$652,964,000**	**$7,093,900**	**$633,282,000**	**$6,963,200**	**-$8,188,000**	
		OTHER ADMINISTRATION SUBTOTAL	**$2,286,519,000**	**$153,495,750**	**$1,861,825,000**	**$170,208,300**	**$1,459,137,000**	**$158,958,100**	**-$827,382,000**	
		GRAND TOTAL ALL ADMIN. ADJUSTMENTS	**$3,980,303,000**	**$909,141,350**	**$3,622,485,000**	**$823,786,850**	**$3,282,347,000**	**$906,232,650**	**-$697,956,000**	

(1) - If no PC # listed at all then dollars were in Appropriation only.

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

NOV. PC #	MAY PC #	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2013 EST. FOR 2014-15 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
		CDHS				
1	1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$253,823,000	$0	$475,650,000	$0
2	2	CCS CASE MANAGEMENT	$179,902,000	$69,636,250	$182,238,000	$71,288,450
3	3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$155,785,000	$0	$151,347,000	$0
4	4	BTR - LIHP - ADMINISTRATIVE COSTS	$115,177,000	$0	$115,177,000	$0
5	5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$13,321,000	$0	-$82,730,000	$0
6	6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,250	$33,718,000	$11,871,250
7	7	SMH MAA	$25,966,000	$0	$24,086,000	$0
8	8	CALHEERS DEVELOPMENT	$19,705,000	$6,327,400	$128,618,000	$25,689,000
9	9	ACA OUTREACH AND ENROLLMENT COUNSELORS	$26,500,000	$13,250,000	$26,500,000	$13,250,000
10	10	TRANSITION OF HFP TO MEDI-CAL	$18,426,000	$6,449,100	$15,937,000	$5,577,950
11	11	ARRA HITECH INCENTIVE PROGRAM	$36,225,000	$3,404,000	$33,725,000	$3,154,000
12	12	POSTAGE & PRINTING	$17,832,000	$9,019,500	$18,832,000	$9,519,500
13	13	ACA EXPANSION ADMIN COSTS	$8,325,000	$4,162,500	$1,155,000	$577,500
14	14	COUNTY UR & QA ADMIN	$17,203,000	$0	$18,272,000	$600,000
15	15	MIS/DSS CONTRACT	$10,900,000	$2,897,000	$12,476,000	$3,317,000
16	16	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000
17	17	CCI-ADMINISTRATIVE COSTS	$8,070,000	$2,543,000	$8,086,000	$2,551,000
18	18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TI	$3,644,000	$539,550	$4,816,000	$679,850
19	19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$6,290,000	$753,600	$8,076,000	$1,184,100
21	21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,913,000	$1,983,750	$5,447,000	$1,800,500
22	22	MEDI-CAL RECOVERY CONTRACTS	$5,709,000	$1,427,250	$5,721,000	$1,430,250
23	23	COORDINATED CARE MANAGEMENT PILOT	$118,000	$59,000	$118,000	$59,000
24		RESTORATION OF SELECT ADULT DENTAL BENEFI	$19,906,000	$6,275,000	$0	$0
25	25	PASRR	$6,400,000	$1,600,000	$8,590,000	$2,147,500
26		ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$2,015,000	$1,003,750	$0	$0
27	27	FAMILY PACT EVALUATION	$2,861,000	$1,430,500	$2,861,000	$1,430,500
28	28	PREVENTION OF CHRONIC DISEASE GRANT PROJE	$2,660,000	$0	$2,660,000	$0
29	29	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,662,000	$1,331,000	$2,662,000	$1,331,000
30	30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$2,487,000	$621,750	$4,815,000	$1,203,750
31	31	SDMC SYSTEM M&O SUPPORT	$1,959,000	$979,500	$3,000,000	$1,500,000

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

NOV. PC #	MAY PC #	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2013 EST. FOR 2014-15 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
		CDHS				
32	32	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500
33	33	BUSINESS RULES EXTRACTION	$1,900,000	$950,000	$2,750,000	$1,375,000
34		MEDS INTERFACE WITH CALHEERS	$477,000	$410,900	$0	$0
35	35	MITA	$481,000	$48,100	$985,000	$98,500
36	36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000
37	37	MMA - DSH ANNUAL INDEPENDENT AUDIT	$856,000	$428,000	$856,000	$428,000
38	38	ENCRYPTION OF PHI DATA	$750,000	$375,000	$750,000	$375,000
39	39	MEDI-CAL INPATIENT SERVICES FOR INMATES	$560,000	$0	$560,000	$0
40	40	MEDS MODERNIZATION	$4,533,000	$453,300	$4,533,000	$453,300
41	41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$567,000	$283,500	$644,000	$322,000
42	42	VITAL RECORDS DATA	$836,000	$0	$836,000	$0
44	44	CCT OUTREACH - ADMINISTRATIVE COSTS	$242,000	$0	$242,000	$0
46	46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$240,000	$120,000	$240,000	$120,000
48	48	DENTAL PAPD PROJECT MANAGER	$239,000	$119,500	$239,000	$119,500
50	50	ANNUAL EDP AUDIT CONTRACTOR	$162,000	$81,000	$162,000	$81,000
51	51	EPOCRATES	$107,000	$53,500	$107,000	$53,500
52	52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMEI	$100,000	$0	$100,000	$0
53	53	TAR POSTAGE	$99,000	$49,500	$115,000	$57,500
54	54	DMHC INTER-AGENCY AGREEMENT - ADMIN	$95,000	$0	$189,000	$0
55	55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$70,000	$35,000	$62,000	$31,000
56	56	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$39,000	$19,500	$59,000	$29,500
57	57	RECOVERY AUDIT CONTRACTOR COSTS	$14,000	$7,000	$12,000	$6,000
58	58	DRUG MEDI-CAL COUNTY ADMINISTRATION	$14,726,000	$4,197,000	$23,029,000	$6,620,000
59	59	NEWBORN HEARING SCREENING PROGRAM	$4,136,000	$2,068,000	$4,136,000	$2,068,000
60	60	RATE STUDIES FOR MAIC AND AAC VENDOR	$1,000,000	$500,000	$1,000,000	$500,000
80	80	THIRD PARTY VALIDATION OF CERTIFIED PROVIDE	$250,000	$125,000	$0	$0
	45	ETL DATA SOLUTION	$0	$0	$325,000	$48,000
	47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$0	$0	$180,000	$45,000
	82	DENTAL FI RE-PROCUREMENT IV&V	$0	$0	$282,000	$70,500
		CDHS SUBTOTAL	**$1,048,118,000**	**$164,431,950**	**$1,266,383,000**	**$179,606,900**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
MAY 2014 ESTIMATE COMPARED TO NOVEMBER 2013 ESTIMATE
FISCAL YEAR 2014-15

NOV. PC #	MAY PC #	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2013 EST. FOR 2014-15 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
		CDHS				
		OTHER DEPARTMENTS				
61	61	PERSONAL CARE SERVICES	$249,240,000	$0	$264,886,000	$0
62	62	HEALTH-RELATED ACTIVITIES - CDSS	$232,467,000	$0	$223,024,000	$0
63	63	CDDS ADMINISTRATIVE COSTS	$31,196,000	$0	$32,240,000	$0
64	64	MATERNAL AND CHILD HEALTH	$29,702,000	$0	$27,503,000	$0
65	65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTE	$25,143,000	$0	$25,143,000	$0
66	66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$27,499,000	$0	$30,928,000	$0
67	67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPC	$17,156,000	$2,533,000	$17,534,000	$2,533,000
68	68	CLPP CASE MANAGEMENT SERVICES	$5,200,000	$0	$5,200,000	$0
69	69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	$7,049,000	$2,784,400	$6,130,000	$2,421,350
70	70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,563,000	$0	$3,523,000	$0
71	71	CDPH I&E PROGRAM AND EVALUATION	$1,237,000	$0	$946,000	$0
72	72	CDDS DENTAL SERVICES	$1,270,000	$1,270,000	$1,197,000	$1,197,000
73	73	KIT FOR NEW PARENTS	$1,017,000	$0	$1,017,000	$0
74	74	QUITLINE ADMINISTRATIVE SERVICES	$2,000,000	$0	$1,000,000	$0
75	75	VETERANS BENEFITS	$956,000	$0	$956,000	$0
76	76	CHHS AGENCY HIPAA FUNDING	$651,000	$0	$651,000	$0
77	77	MERIT SYSTEM SERVICES FOR COUNTIES	$195,000	$97,500	$195,000	$97,500
79	79	PIA EYEWEAR COURIER SERVICE	$360,000	$180,000	$440,000	$220,000
		OTHER DEPARTMENTS SUBTOTAL	**$635,901,000**	**$6,864,900**	**$642,513,000**	**$6,468,850**
		OTHER ADMINISTRATION SUBTOTAL	**$1,684,019,000**	**$171,296,850**	**$1,908,896,000**	**$186,075,750**
		GRAND TOTAL ALL ADMIN. ADJUSTMENTS	**$3,361,912,000**	**$677,786,750**	**$3,724,430,000**	**$757,339,550**

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

MAY PC#	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14 TOTAL FUNDS	MAY 2014 EST. FOR 2013-14 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
	CDHS				
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$92,000,000	$0	$475,650,000	$0
2	CCS CASE MANAGEMENT	$175,461,000	$68,665,300	$182,238,000	$71,288,450
3	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$133,924,000	$0	$151,347,000	$0
4	BTR - LIHP - ADMINISTRATIVE COSTS	$102,861,000	$0	$115,177,000	$0
5	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$43,877,000	$0	-$82,730,000	$0
6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,250	$33,718,000	$11,871,250
7	SMH MAA	$22,830,000	$0	$24,086,000	$0
8	CALHEERS DEVELOPMENT	$30,603,000	$8,130,650	$128,618,000	$25,689,000
9	ACA OUTREACH AND ENROLLMENT COUNSELORS	$26,500,000	$13,250,000	$26,500,000	$13,250,000
10	TRANSITION OF HFP TO MEDI-CAL	$25,272,000	$8,845,200	$15,937,000	$5,577,950
11	ARRA HITECH INCENTIVE PROGRAM	$11,206,000	$984,000	$33,725,000	$3,154,000
12	POSTAGE & PRINTING	$18,057,000	$9,119,500	$18,832,000	$9,519,500
13	ACA EXPANSION ADMIN COSTS	$905,000	$452,500	$1,155,000	$577,500
14	COUNTY UR & QA ADMIN	$16,440,000	$0	$18,272,000	$600,000
15	MIS/DSS CONTRACT	$10,900,000	$2,892,750	$12,476,000	$3,317,000
16	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000
17	CCI-ADMINISTRATIVE COSTS	$9,217,000	$2,758,500	$8,086,000	$2,551,000
18	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRAN	$8,348,000	$1,621,600	$4,816,000	$679,850
19	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$6,016,000	$802,600	$8,076,000	$1,184,100
20	ADHC TRANSITION-ADMINISTRATION	$6,172,000	$3,086,000	$0	$0
21	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,188,000	$1,715,250	$5,447,000	$1,800,500
22	MEDI-CAL RECOVERY CONTRACTS	$5,266,000	$1,316,500	$5,721,000	$1,430,250
23	COORDINATED CARE MANAGEMENT PILOT	$4,716,000	$2,358,000	$118,000	$59,000
24	RESTORATION OF SELECT ADULT DENTAL BENEFITS	$1,778,000	$444,500	$0	$0
25	PASRR	$3,176,000	$794,000	$8,590,000	$2,147,500
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

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

MAY PC#	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14 TOTAL FUNDS	MAY 2014 EST. FOR 2013-14 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
	CDHS				
29	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,400,000	$1,200,000	$2,662,000	$1,331,000
30	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$2,488,000	$622,000	$4,815,000	$1,203,750
31	SDMC SYSTEM M&O SUPPORT	$1,500,000	$750,000	$3,000,000	$1,500,000
32	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500
33	BUSINESS RULES EXTRACTION	$0	$0	$2,750,000	$1,375,000
35	MITA	$338,000	$33,800	$985,000	$98,500
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000
37	MMA - DSH ANNUAL INDEPENDENT AUDIT	$1,284,000	$642,000	$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	$546,000	$54,600	$4,533,000	$453,300
41	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$597,000	$298,500	$644,000	$322,000
42	VITAL RECORDS DATA	$90,000	$0	$836,000	$0
44	CCT OUTREACH - ADMINISTRATIVE COSTS	$485,000	$0	$242,000	$0
45	ETL DATA SOLUTION	$469,000	$77,900	$325,000	$48,000
46	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$400,000	$200,000	$240,000	$120,000
47	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$216,000	$54,000	$180,000	$45,000
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
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0
53	TAR POSTAGE	$111,000	$55,500	$115,000	$57,500
54	DMHC INTER-AGENCY AGREEMENT - ADMIN	$158,000	$0	$189,000	$0
55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$62,000	$31,000	$62,000	$31,000
56	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$63,000	$31,500	$59,000	$29,500
57	RECOVERY AUDIT CONTRACTOR COSTS	$1,000	$500	$12,000	$6,000

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

MAY PC#	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14 TOTAL FUNDS	MAY 2014 EST. FOR 2013-14 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
	CDHS				
58	DRUG MEDI-CAL COUNTY ADMINISTRATION	$0	$0	$23,029,000	$6,620,000
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	$0	$0
82	DENTAL FI RE-PROCUREMENT IV&V	$0	$0	$282,000	$70,500
	CDHS SUBTOTAL	**$825,855,000**	**$151,994,900**	**$1,266,383,000**	**$179,606,900**
	OTHER DEPARTMENTS				
61	PERSONAL CARE SERVICES	$252,272,000	$0	$264,886,000	$0
62	HEALTH-RELATED ACTIVITIES - CDSS	$216,528,000	$0	$223,024,000	$0
63	CDDS ADMINISTRATIVE COSTS	$39,021,000	$0	$32,240,000	$0
64	MATERNAL AND CHILD HEALTH	$25,870,000	$0	$27,503,000	$0
65	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER C	$25,143,000	$0	$25,143,000	$0
66	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$31,598,000	$0	$30,928,000	$0
67	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	$19,012,000	$2,780,000	$17,534,000	$2,533,000
68	CLPP CASE MANAGEMENT SERVICES	$7,400,000	$0	$5,200,000	$0
69	SINGLE POINT OF ENTRY - MEDI-CAL ONLY	$6,832,000	$2,698,700	$6,130,000	$2,421,350
70	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,129,000	$0	$3,523,000	$0
71	CDPH I&E PROGRAM AND EVALUATION	$1,028,000	$0	$946,000	$0
72	CDDS DENTAL SERVICES	$1,197,000	$1,197,000	$1,197,000	$1,197,000
73	KIT FOR NEW PARENTS	$1,017,000	$0	$1,017,000	$0
74	QUITLINE ADMINISTRATIVE SERVICES	$1,000,000	$0	$1,000,000	$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 OUTREA	$53,000	$0	$0	$0
79	PIA EYEWEAR COURIER SERVICE	$380,000	$190,000	$440,000	$220,000

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

MAY PC#	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14 TOTAL FUNDS	MAY 2014 EST. FOR 2013-14 STATE FUNDS	MAY 2014 EST. FOR 2014-15 TOTAL FUNDS	MAY 2014 EST. FOR 2014-15 STATE FUNDS
	OTHER DEPARTMENTS				
	OTHER DEPARTMENTS SUBTOTAL	$633,282,000	$6,963,200	$642,513,000	$6,468,850
	OTHER ADMINISTRATION SUBTOTAL	$1,459,137,000	$158,958,100	$1,908,896,000	$186,075,750
	GRAND TOTAL COUNTY AND OTHER ADMIN.	$3,282,347,000	$906,232,650	$3,724,430,000	$757,339,550

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	CDHS
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 COUNSELORS
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-ADMINISTRATIVE COSTS
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
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
35	MITA
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES
37	MMA - DSH ANNUAL INDEPENDENT AUDIT
38	ENCRYPTION OF PHI DATA

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	CDHS
39	MEDI-CAL INPATIENT SERVICES FOR INMATES
40	MEDS MODERNIZATION
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 ACQUISTION
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
82	DENTAL FI RE-PROCUREMENT IV&V
	OTHER DEPARTMENTS
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
71	CDPH I&E PROGRAM AND EVALUATION

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER DEPARTMENTS
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	$92,000,000	$475,650,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$92,000,000	$475,650,000

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. In June 2012, CMS deferred the school based MAA (SMAA) program retroactively to October 2011. During the deferral period, schools will continue to submit invoices which will be processed as an "Early Claim" in order to meet the two-year retrospective federal claiming limitation. CMS will release deferred invoices on a flow basis as certain criteria are met and a new SMAA manual is implemented.

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 release of deferred School-based MAA claims were delayed, and are expected to be fully released in FY 2014-15.

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

Methodology:

1. Assume an annual growth rate of 5%.

2. Total MAA reimbursements FY 2013-14 and FY 2014-15 on a cash basis are:

(Dollars In Thousands)

FY 2013-14	**TF**	**FF**
County MAA	68,250	68,250
Tribal MAA	1,050	1,050
School MAA	22,700	22,700
Total	**92,000**	**92,000**

FY 2014-15	**TF**	**FF**
County MAA	103,950	103,950
Tribal MAA	1,050	1,050
School MAA	370,650	370,650
Total	**475,650**	**475,650**

Funding:

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

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/1999
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	230

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$175,461,000	$182,238,000
STATE FUNDS	$68,665,300	$71,288,450
FEDERAL FUNDS	$106,795,700	$110,949,550

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 Net (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 began transitioning May 2013.

A portion of CCS case management transitioned 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 x (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 $2,744,000 in FY 2013-14 and $2,747,000 in FY 2014-15.

5. The HFP transitioning into Medi-Cal consists of the following costs

	FY 2013-14	FY 2014-15
County Administration:	$27,493,000	$31,517,000

6. County data processing costs associated with CMS Net for CCS HFP are estimated to be $471,000 in FY 2013-14 and $465,000 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.

FY 2013-14	**TF**	**GF**	**FF**	**Reimburse-ment***
CCS Medi-Cal				
CCS Case Management	$146,642,000	$57,916,000	$88,726,000	
Pediatric Palliative Care	$750,000	$188,000	$563,000	
CMS Net	$2,744,000	$1,372,000	$1,372,000	
	$150,136,000	$59,476,000	$90,661,000	$0
Healthy Families Transition				
CCS Case Management	$27,493,000	$4,811,000	$17,870,000	$4,811,000
CMS Net	$471,000	$165,000	$306,000	
	$27,964,000	$4,976,000	$18,176,000	$4,811,000
Health Plan of San Mateo	($2,639,000)	($1,320,000)	($1,320,000)	
Total	**$175,461,000**	**$63,132,000**	**$107,517,000**	**$4,811,000**

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

FY 2014-15	TF	GF	FF	Reimbursement*
CCS Medi-Cal				
CCS Case Management	$149,194,000	$58,924,000	$90,270,000	
Pediatric Palliative Care	$751,000	$188,000	$563,000	
CMS Net	$2,747,000	$1,374,000	$1,374,000	
	$152,692,000	$60,486,000	$92,207,000	$0
Healthy Families Transition				
CCS Case Management	$31,517,000	$5,516,000	$20,486,000	$5,516,000
CMS Net	$465,000	$163,000	$302,000	
	$31,982,000	$5,679,000	$20,788,000	$5,516,000
Health Plan of San Mateo	($2,436,000)	($1,218,000)	($1,218,000)	$0
Total**	**$182,238,000**	**$64,947,000**	**$111,777,000**	**$5,516,000**

**Amounts differ due to rounding.

Funding:
(Dollars in Thousands)

FY 2013-14	TF	GF	FF	County
50% Title XIX / 50% GF (4260-101-0001/0890)	$85,128	$42,564	$42,564	
75% Title XIX / 25% GF (4260-101-0001/0890)	$62,369	$15,592	$46,777	
65% Title XXI / 35% GF (4260-113-0001/0890)	$23,153	$4,976	$18,177	
100% Reimbursement GF (4260-610-0995)*	$4,811	$0	$0	$4,811
Total	$175,461	$63,132	$107,518	$4,811

FY 2014-15	TF	GF	FF	County
50% Title XIX / 50% GF (4260-101-0001/0890)	$86,814	$43,407	$43,407	
75% Title XIX / 25% GF (4260-101-0001/0890)	$63,442	$15,861	$47,582	
65% Title XXI / 35% GF (4260-113-0001/0890)	$26,467	$5,678	$20,788	
100% Reimbursement GF (4260-610-0995)*	$5,516	$0	$0	$5,516
Total**	$182,239	$64,946	$111,777	$5,516

**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	$133,924,000	$151,347,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$133,924,000	$151,347,000

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:
Medi-Cal administrative costs for specialty mental health services (SMHS) decreased slightly based on revised payment lag factors.

Methodology:
1. 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)

Fiscal Year	Total	FFP	County
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 35% of each fiscal year claims will be paid in the year the services occur. Assume 64% is paid in the following year and an additional 1% in the third year.

(Dollars In Thousands)

Fiscal Year	Accrual	FY 2012-13	FY 2013-14	FY 2014-15
MC	$255,988	$89,596	$163,832	$2,560
HFP	$1,935	$677	$1,238	$20
M-CHIP	$844	$295	$541	$8
FY 2012-13	$258,767	$90,568	$165,611	$2,588
MC	$287,592	$0	$100,657	$184,059
HFP	$34	$0	$12	$22
M-CHIP	$2,261	$0	$791	$1,447
FY 2013-14	$289,887	$0	$101,460	$185,528
MC	$323,313	$0	$0	$113,160
M-CHIP	$2,131	$0	$0	$746
FY 2014-15	$325,444	$0	$0	$113,906

3. Mental Health administration costs are shared between federal funds participation (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)

	FY 2013-14			FY 2014-15		
Claims	TF	FFP	County	TF	FFP	County
MC	$264,490	$132,245	$132,245	$299,779	$149,889	$149,890
HFP*	$1,250	$813	$437	$42	$27	$15
M-CHIP*	$1,332	$866	$466	$2,201	$1,431	$770
Total	$267,072	**$133,924**	$133,148	$302,022	**$151,347**	$150,675

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, consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were 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 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided 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 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 received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

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

Methodology:
1. Administrative payments will be based on the CMS approved administrative cost claiming protocol and time study.

BTR - LIHP - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 4

2. Invoices for administrative payments for FY 2011-12, FY 2012-13, and FY 2013-14 will be processed in FY 2013-14 and FY 2014-15.

3. Estimates for start-up costs are based on historical data and will be processed in FY 2013-14 and FY 2014-15.

4. Estimated administrative costs are expected to be as follows:

	LIHP-HCCI	LIHP-MCE	Total FFP
FY 2013-14			
FY 2011-12	$2,416,000	$34,414,000	$36,830,000
FY 2012-13	$1,486,000	$35,678,000	$37,164,000
FY 2013-14	$1,154,000	$27,713,000	$28,867,000
Total	**$5,056,000**	**$97,805,000**	**$102,861,000**
FY 2014-15			
FY 2011-12	$957,000	$22,969,000	$23,926,000
FY 2012-13	$2,495,000	$59,889,000	$62,384,000
FY 2013-14	$1,154,000	$27,713,000	$28,867,000
Total	**$4,606,000**	**$110,571,000**	**$115,177,000**

Funding:
100% Title XIX 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	$43,877,000	-$82,730,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$43,877,000	-$82,730,000

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 payments 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 these 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 an 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:
The Department does not anticipate completing interim settlement for FY 2010-11 in the current year and has moved the interim settlement to the budget year.

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)	Underpaid	Overpaid	Net FFP
Interim Settlements (FY 2008-09)			
SMH Admin	$26,316	($14,481)	$11,835
UR/QA	$13,341	($1,103)	$12,238
MH MAA	$1,787	($1,728)	$59
Interim Settlements (FY 2009-10)			
SMH Admin	$31,215	($20,210)	$11,005
M CHIP*	$843	$0	$843
UR/QA	$13,633	($3,031)	$10,602
MH MAA	$960	($5,077)	($4,117)
Healthy Families*	$1,412	$0	$1,412
Total FY 2013-14	$89,507	($45,630)	**$43,877**

(Dollars in Thousands)	Underpaid	Overpaid	Net FFP
Interim Settlements (FY 2010-11)			
SMH Admin	$18,485	($61,190)	($42,705)
M-CHIP*	$581	$0	$581
UR/QA	$14,063	($8,780)	$5,283
MHMAA	$677	($28,612)	($27,935)
Healthy Families*	$1,331	$0	$1,331
Interim Settlements (FY 2011-12)			
SMH Admin	$54,065	($52,705)	$1,360
M-CHIP*	$46	($1,451)	($1,405)
UR/QA	$13,356	($22,974)	($9,618)
MHMAA	$579	($11,469)	($10,890)
Healthy Families*	$1,268	$0	$1,268
Total FY 2014-15	$104,451	($187,181)	**($82,730)**

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:	Stephanie Hockman
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:
1. 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
Allocation	**$33,718,000**	**$11,871,000**	**$21,847,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% Title XIX (4260-101-0890)

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1722

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$22,830,000	$24,086,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$22,830,000	$24,086,000

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:
The estimates are revised to account for the most recent claims data.

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 2012-13, the average annual increase in mental health (MH) Medi-Cal administrative activities (MAA) claims was 5.50%.

3. Assume claims will continue to increase by 5.50% each year for FY 2012-13, FY 2013-14, and FY 2014-15.

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 7

4. For FY 2012-13, the Department received $38,271,000 in MH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
FY 2012-13	$38,271	5.50%	$2,105
FY 2013-14	$40,376	5.50%	$2,221
FY 2014-15	$42,597	5.50%	$2,343

5. Based on historical claims received, assume 40% of fiscal year claims will be paid in the year the services occur. The remaining 60% is paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2013-14	FY 2014-15
FY 2012-13	$38,271	$22,963	$0
FY 2013-14	$40,376	$16,150	$24,226
FY 2014-15	$42,597	$0	$17,039
Total	$121,244	$39,113	$41,265

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)

	FY 2013-14			FY 2014-15		
Fiscal Year	**TF**	**FFP**	**County**	**TF**	**FFP**	**County**
Medical	$13,096	**$9,822**	$3,274	$13,816	**$10,362**	$3,454
Other	$26,017	**$13,008**	$13,009	$27,448	**$13,724**	$13,724
Total	$39,113	**$22,830**	$16,283	$41,264	**$24,086**	$17,178

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$30,603,000	$128,618,000
STATE FUNDS	$8,130,650	$25,689,000
FEDERAL FUNDS	$22,472,350	$102,929,000

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). This policy change also includes the cost for contractors and staff to integrate the Medi-Cal Eligibility Data System (MEDS) into the 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 Covered California to provide competitive health care coverage for individuals and small employers. As required by ACA, States will use Covered California's new CalHEERs 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, or with the Medicaid and Children's Health Insurance Program agency. To meet this requirement, the Department and Covered California 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.

CalHEERS will be programmed to provide Modified Adjusted Gross Income eligibility determinations for individuals seeking coverage through Covered California and Medi-Cal. 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.

ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department will also 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. Medi-Cal's associated cost for the one-time development and implementation of CalHEERS is 18%; 17% is 10/90 FFP and 1% is 35/65 FFP. CalHEERS ongoing Operations and

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Maintenance (O&M) cost is 18%; 17% is 25/75 FFP and 1% is 35/65 FFP. CalHEERS' costs are shared between Covered California (82%) and Medi-Cal (18%). Covered California will reimburse the Department for their share.

The Department is hiring nine 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.

Reason for Change from Prior Estimate:
Costs have been updated due to changes in the scope of the project and the MEDS Interface with CalHEERs policy change has been incorporated into the CalHEERS Development policy change.

Methodology:

1. Contractors began development and implementation (D&I) work in July 2012. Assume contractors will begin maintenance and operations (M&O) in January 2015.

2. The consultants began D&I work on the MEDS Interface project in November 2012. Payments began in December 2012.

3. CalHEERS' costs are shared between Covered California (82%) and Medi-Cal (18%). Covered California will reimburse the Department for their share.

4. In FY 2012-13 and FY 2013-14, costs incurred are for CalHEERS' D&I. In DY 2014-15, costs incurred are for CalHEERS' D&I and M&O.

   The design, development, and implementation period is eligible for:

   - 17% at 90% federal reimbursement
   - 1% at 65% federal reimbursement

   The design, development, and implementation period is eligible for:

   - 17% at 75% federal reimbursement
   - 1% at 65% federal reimbursement

	TF	GF	FF	REIMBURSEMENTS
Total FY 2013-14:	**$30,603,000**	**$3,709,000**	**$22,472,000**	**$4,422,000**
Total FY 2014-15:	**$128,618,000**	**$22,327,000**	**$102,929,000**	**$3,362,000**

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)

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	3/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1820

	FY 2013-14	FY 2014-15
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 enrollment counselors 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 enrollment counselors. 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 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 COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER: 9

Reason for Change from Prior Estimate:
There is no 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:

FY 2013-14	TF	Special Fund	FF
Enrollment Counselors	$14,000,000	$7,000,000	$7,000,000
Outreach and Enrollment	$12,500,000	$6,250,000	$6,250,000
Total	**$26,500,000**	**$13,250,000**	**$13,250,000**

FY 2014-15	TF	Special Fund	FF
Enrollment Counselors	$14,000,000	$7,000,000	$7,000,000
Outreach and Enrollment	$12,500,000	$6,250,000	$6,250,000
Total	**$26,500,000**	**$13,250,000**	**$13,250,000**

Funding:
50% Title XIX FFP (4260-101-0890)
50% Healthcare Outreach Fund (4260-601-0942285)

TRANSITION OF HFP TO MEDI-CAL

OTHER ADMIN. POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	1/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1650

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$25,272,000	$15,937,000
STATE FUNDS	$8,845,200	$5,577,950
FEDERAL FUNDS	$16,426,800	$10,359,050

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.

Beginning January 1, 2014, the Department instructed MAXIMUS to close out the Single Point of Entry (SPE) application services and to refer applicants to use the application portal and toll-free line at Covered California. The shutdown process will be completed in FY 2013-14.

Beginning November 1, 2013, the Access for Infants and Mothers (AIM) infants above the 250% of poverty level transitioned into the Medi-Cal program. The transition ended on February 1, 2014.

Beginning July 1, 2014, the AIM mothers will transition into the Medi-Cal program.

Reason for Change from Prior Estimate:
Actual certified eligible data (September 2013 through February 2014) was incorporated into the updated caseload projections which showed a decrease in caseload. The close out of the SPE in FY 2013-14. Two new AIM populations are being added to the estimate.

TRANSITION OF HFP TO MEDI-CAL

OTHER ADMIN. POLICY CHANGE NUMBER: 10

Methodology:

1. Estimated costs:

(In Thousands)	TF	GF	FF
FY 2013-14	**$25,272**	$8,845	$16,427

	TF	GF	FF
FY 2014-15	**$15,937**	$5,578	$10,359

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	$11,206,000	$33,725,000
STATE FUNDS	$984,000	$3,154,000
FEDERAL FUNDS	$10,222,000	$30,571,000

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-177 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 certified Electronic Health Records (EHR) technology in accordance with the HITECH Act requirements. The Centers for Medicare and Medicaid Services (CMS) 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. The HITECH Act pays provider incentive payments at 100% Federal Financial Participation (FFP).

In 2011, SB 945 authorized the Department to establish and administer the ARRA HITECH Incentive Program only to the extent that 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 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 September 9, 2013. The authorization provides additional funds for meaningful use (MU) measures including immunization registries and provider technical assistance.

The Department is required by CMS to assess the current usage of and barriers to EHR adoption by

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 11

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 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:
For FY 2013-14, the amount budgeted for providing technical assistance to providers was reduced.

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

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 11

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.

FY 2013-14:	**TF**	**Reimbursement**	**FF**
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)	$7,500,000	$750,000	$6,750,000
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
Total	**$11,206,000**	**$984,000**	**$10,222,000**

	TF	**GF**	**FF**
Xerox projects (In FI Estimate)	$3,200,000	$320,000	$2,880,000
Total FY 2013-14	$14,406,000	$1,304,000	$13,102,000

FY 2014-15:	**TF**	**Reimbursement**	**FF**
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)	$30,000,000	$3,000,000	$27,000,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$1,381,000
Total	**$33,725,000**	**$3,154,000**	**$30,571,000**

	TF	**GF**	**FF**
Xerox projects (In FI Estimate)	$800,000	$80,000	$720,000
Total FY 2014-15	$34,525,000	$3,234,000	$31,291,000

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$18,057,000	$18,832,000
STATE FUNDS	$9,119,500	$9,519,500
FEDERAL FUNDS	$8,937,500	$9,312,500

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 to existing beneficiaries at least every 3 years. 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% general fund (GF) and Healthy Families are 35% GF/65% federal financial participation (FFP).

Reason for Changes from Prior Estimate:
Lowered FY 2013-14 costs were a result of the ACA Express Lane Enrollment mailing costs being incurred in the Fiscal Intermediary (FI) line item. The higher FY 14-15 expenses are due to the postage increase.

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 12

Methodology:

1. Estimated costs were provided by the Medi-Cal Eligibility Division (MCED).

(Dollars in Thousands)

FY 2013-14		**Printing**	**Mailing**	**TF**	**GF**	**FF**
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	$25
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
TOTAL (Rounded)		$5,753	$12,304	**$18,057**	**$9,120**	**$8,937**

(Dollars in Thousands)

FY 2014-15		**Printing**	**Mailing**	**TF**	**GF**	**FF**
Mass Mailings		$0	$9,000	$9,000	$4,500	$4,500
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	$25
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
TOTAL (Rounded)		$5,628	$13,204	**$18,832**	**$9,520**	**$9,312**

Funding:

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

ACA EXPANSION ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	9/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1795

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$905,000	$1,155,000
STATE FUNDS	$452,500	$577,500
FEDERAL FUNDS	$452,500	$577,500

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 and actuarial work related to rate development.

Reason for Change from Prior Estimate:
Costs related to system modifications, postage and printing costs were moved into the Fiscal Intermediary (FI) tab of the estimate. Also, estimated costs for IT consultant services and actuarial work were updated.

Methodology:
1. The Department estimates IT consultant services and actuarial costs for the new ACA expansion population are:

(Dollars in Thousands)	FY 2013-14			FY 2014-15		
	TF	GF	FF	TF	GF	FF
Consultant Services	$905	$452	$453	$1,155	$577	$578

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	$16,440,000	$18,272,000
STATE FUNDS	$0	$600,000
FEDERAL FUNDS	$16,440,000	$17,672,000

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. The other administrative costs related to the Katie A. v. Bontá settlement agreement have been added in FY 2014-15.

Methodology:
1. UR and QA expenditures are shared between federal funds participation (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	$16,426	$8,845
FY 2013-14	$25,957	$16,872	$9,085
FY 2014-15	$26,740	$17,381	$9,359

3. Based on historical claims received, assume 40% of the each fiscal year claims will be paid in the year the services occur. Assume 59% is paid in the following year and 1% is paid in the third year.

COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 14

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2013-14	FY 2014-15
FY 2012-13	$25,271	$14,910	$253
FY 2013-14	$25,957	$10,383	$15,315
FY 2014-15	$26,740	$0	$10,696
Total		$25,293	$26,264

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.

6. An additional $1,200,000 has been added to Other personnel costs in FY 2014-15 to prepare semi-annual reports for the Katie A. v. Bontá settlement agreement. The Katie A. v. Bontá settlement agreement costs are eligible for 50% FFP and 50% General Fund (GF).

(Dollars in Thousands)

	FY 2013-14			FY 2014-15			
Personnel	**TF**	**FFP**	**CF**	**TF**	**FFP**	**CF**	**GF**
Other	$10,117	$5,058	$5,059	$11,706	$5,853	$5,253	$600
Medical	$15,176	$11,382	$3,794	$15,758	$11,819	$3,939	$0
Total	$25,293	**$16,440**	$8,853	$27,464	**$17,672**	$9,192	**$600**

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

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	$12,476,000
STATE FUNDS	$2,892,750	$3,317,000
FEDERAL FUNDS	$8,007,250	$9,159,000

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. The Department plans to award a new contract for the ongoing maintenance and operation of the MIS/DSS in January 2015. There will be an overlap period of about six months to allow the new contractor to takeover operations, and the existing contractor to phase out.

Reason for Change from Prior Estimate:
The estimate for FY 2014-15 has been updated to include MIS/DSS Data Warehouse maintenance and operation costs for an overlap period of six months where the new contractor will be phasing in.

Methodology:
1. It is estimated that the contractor will be paid the following amounts in FY 2013-14 and FY 2014-15:

FY 2013-14:	TF	GF	FF
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
Total	**$10,900,000**	**$2,893,000**	**$8,007,000**

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 15

FY 2014-15:	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$8,875,000	$2,219,000	$6,656,000
Additional Fixed Costs (50% FF / 50% GF)	$792,000	$396,000	$396,000
Variable Costs (75% FF / 25% GF)	$2,809,000	$702,000	$2,107,000
Total	**$12,476,000**	**$3,317,000**	**$9,159,000**

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

	FY 2013-14	FY 2014-15
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
Total	**$ 9,980,000**	**$ 4,990,000**	**$ 9,980,000**	**$ 4,990,000**

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

CCI-ADMINISTRATIVE COSTS

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	$9,217,000	$8,086,000
STATE FUNDS	$2,758,500	$2,551,000
FEDERAL FUNDS	$6,458,500	$5,535,000

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)
Interagency Agreement (IA) # 13-90037

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),
- Ombudsman – Infrastructure Development,
- IT Project Management, and
- Data Outcomes and Evaluation Development.

Reason for Change from Prior Estimate:
Additional stakeholder outreach activities are being conducted in FY 2013-14 and FY 2014-15. Also, in FY 2013-14 there is a one-time administrative processing fee to California Department of Social Services (CDSS) that was not included in the November estimate.

Methodology:
1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2015-16.

CCI-ADMINISTRATIVE COSTS

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.

3. The Department has an interagency agreement (IA# 13-90037) with CDSS to design a system and distribute case management information containing IHSS recipient data to CCI plans. In FY 2013-14, the Department will pay CDSS a one-time administrative processing fee of $420,000.

2013-14 Costs	**TF**	**GF**	**FFP**	**ACA FFP**
Stakeholder and Advocate Outreach	$5,083,000	$2,541,500	$2,541,500	$0
Rate Setting	$510,000	$0	$0	$510,000
Data Analysis	$250,000	$0	$0	$250,000
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
Administrative Fee (IA# 13-90037)	$420,000	$210,000	$210,000	$0
Total	**$9,217,000**	**$2,758,500**	**$2,758,500**	**$3,700,000**

2014-15 Costs	**TF**	**GF**	**FFP**	**ACA FFP**
Stakeholder and Advocate Outreach	$3,832,000	$1,916,000	$1,916,000	$0
Rate Setting	$510,000	$0	$0	$510,000
Data Analysis	$250,000	$0	$0	$250,000
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
Total	**$8,086,000**	**$2,551,000**	**$2,551,000**	**$2,984,000**

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$8,348,000	$4,816,000
STATE FUNDS	$1,621,600	$679,850
FEDERAL FUNDS	$6,726,400	$4,136,150

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 both fiscal years, 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

FY 2013-14:	TF	GF	FF
50% Title XXI / 50% GF	$38,000	$19,000	$19,000
75% Title XIX / 25% GF	$4,142,000	$1,035,000	$3,107,000
90% Title XIX / 10% GF	$4,001,000	$400,000	$3,601,000
100% GF	$167,000	$167,000	$0
Total	**$8,348,000**	**$1,621,000**	**$6,727,000**

FY 2014-15:	TF	GF	FF
50% Title XXI / 50% GF	$22,000	$11,000	$11,000
75% Title XIX / 25% GF	$687,000	$172,000	$515,000
90% Title XIX / 10% GF	$4,011,000	$401,000	$3,610,000
100% GF	$96,000	$96,000	$0
Total	**$4,816,000**	**$680,000**	**$4,136,000**

Funding:
50% Title XXI / 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	$6,016,000	$8,076,000
STATE FUNDS	$802,600	$1,184,100
FEDERAL FUNDS	$5,213,400	$6,891,900

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 decreased due to the realignment of expected invoicing dates. For FY 2014-15, costs increased due to the revised expected costs for contracts that are in the process of being procured.

Methodology:
1. The estimated costs are based upon the contract provisions.

FY 2013-14:	TF	GF	FF
50% Title XXI / 50% GF	$27,000	$13,000	$14,000
75% Title XIX / 25% GF	$548,000	$137,000	$411,000
90% Title XIX / 10% GF	$5,321,000	$532,000	$4,789,000
100% GF	$120,000	$120,000	$0
Total	**$6,016,000**	**$802,000**	**$5,214,000**

CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER: 19

FY 2014-15:	TF	GF	FF
50% Title XXI / 50% GF	$36,000	$18,000	$18,000
75% Title XIX / 25% GF	$1,448,000	$362,000	$1,086,000
90% Title XIX / 10% GF	$6,431,000	$643,000	$5,788,000
100% GF	$161,000	$161,000	$0
Total	**$8,076,000**	**$1,184,000**	**$6,892,000**

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 former 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:
There is no change.

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	
	TF	**GF**
FFS Assessment & Care Coordination	$88	$44
Fair Hearing Costs	$2,082	$1,041
Administrative Law Judge Costs	$4,002	$2,001
Total	**$6,172**	**$3,086**

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	$5,188,000	$5,447,000
STATE FUNDS	$1,715,250	$1,800,500
FEDERAL FUNDS	$3,472,750	$3,646,500

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.

Costs are offset by reimbursements made from other departments.

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. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.

MEDS includes supporting the Advance Premium Tax Credit (APTC) and Cost Share Reduction (CSR) programs beginning January 2014. The MEDS system will develop unique identifiers for the new population.

Reason for Change from Prior Estimate:
Costs were revised based on actual expenditures and projections for FY 2014-15 were updated based on current actual expenditures.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 21

Methodology:

1. The following projections are based on actual data from July 2013 through February 2014.

FY 2013-14:	**TF**	**GF**	**FF**
(50% FF / 50% GF)	$512,000	$256,000	$256,000
(75% FF / 25% GF)	$4,289,000	$1,072,000	$3,217,000
(100% Reimbursement)	$387,000	$387,000	$0
Total	**$5,188,000**	**$1,715,000**	**$3,473,000**

FY 2014-15:	**TF**	**GF**	**FF**
(50% FF / 50% GF)	$537,000	$268,000	$269,000
(75% FF / 25% GF)	$4,504,000	$1,126,000	$3,378,000
(100% Reimbursement)	$406,000	$406,000	$0
Total	**$5,447,000**	**$1,800,000**	**$3,647,000**

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:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1551

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$5,266,000	$5,721,000
STATE FUNDS	$1,316,500	$1,430,250
FEDERAL FUNDS	$3,949,500	$4,290,750

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
Department of Public Health	10-87020 A01
Department of Public Health	13-90373

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 WC 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 WC 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 health insurance contract was awarded to Health Management Systems with an effective date of December 1, 2013 and ends on November 30, 2018.

The WC contract was awarded to Health Management Systems with an effective date of May 1, 2013 and ends on April 30, 2017.

Reason for Change from Prior Estimate:
The costs have been adjusted based on actual expenditures as well as the addition of two new Department of Public Health contracts.

Methodology:
1. The amounts paid to the contractors are based upon recoveries. The payments shown below include recent recovery activity.

FY 2013-14	TF	GF	FF
Health Insurance	$4,757,000	$1,189,000	$3,568,000
WC	$419,000	$105,000	$314,000
Online Database Contracts	$90,000	$23,000	$67,000
Total	**$5,266,000**	**$1,317,000**	**$3,949,000**

FY 2014-15	TF	GF	FF
Health Insurance	$5,100,000	$1,275,000	$3,825,000
WC	$529,000	$132,000	$397,000
Online Database Contracts	$92,000	$23,000	$69,000
Total	**$5,721,000**	**$1,430,000**	**$4,291,000**

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:	Randolph Alarcio
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 began 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.

FY 2013-14	TF	GF	FF
CCM1	$0	$0	$0
CCM2	$4,612,000	$2,306,000	$2,306,000
UCLA IE	$104,000	$52,000	$52,000
Total	**$4,716,000**	**$2,358,000**	**$2,358,000**

FY 2014-15	TF	GF	FF
CCM1	$0	$0	$0
CCM2	$0	$0	$0
UCLA IE	$118,000	$59,000	$59,000
Total	**$118,000**	**$59,000**	**$59,000**

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	$1,778,000	$0
STATE FUNDS	$444,500	$0
FEDERAL FUNDS	$1,333,500	$0

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). Additionally, effective September 26, 201, per the United States Court of Appeals for the Ninth Circuit in the case of California Association of Rural Health Clinics, et al., v. Toby Douglas, Director of the California Department of Health Care Services, et al., Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs) may also provide services pursuant to the scope of covered adult dental benefits available on June 30, 2009.

AB 82 restores partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services that can be offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including FQHCs and RHCs, will be limited to the adult optional benefits being restored May 1, 2014, in addition to the current scope of adult dental benefits which include pregnancy-related services, emergency services, FRADs, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers.

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.

RESTORATION OF SELECT ADULT DENTAL BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 24

State Plan Amendment (SPA) 13-018 which makes the necessary changes to the State Plan to reflect the restoration of select adult dental benefits was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 30, 2013.

Reason for Change from Prior Estimate:
The methodology changed from charging a rate per member to price based on volume of ACLs/TARs processed. The FY 2014-15 funds have been incorporated into the Dental FI policy.

Methodology:

1. Based on the volume level of ACLs/TARs Delta processed, the Department pays Delta Dental a fixed price.

2. The FY 2014-15 funds have been incorporated into the Dental FI policy.

3. Based on the estimated number of incidences, the estimated cost will be:

	TF	GF	FF
FY 2013-14	**$ 1,778,000**	**$ 444,500**	**$ 1,333,500**

Funding:
75% Title XIX / 25% GF 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	$3,176,000	$8,590,000
STATE FUNDS	$794,000	$2,147,500
FEDERAL FUNDS	$2,382,000	$6,442,500

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 new contract will begin in July 2014 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,
- Reduce the time a contractor takes to return completed evaluations, and
- Increase efficiencies for PASRR clinicians by reducing processing time for determinations.

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 25

Reason for Change from Prior Estimate:
Due to a delay in the project, 44% of the estimated IT project cost will carry over to FY 2014-15. In addition, there is a projected increase in the number of evaluations expected for 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. As of February 2014, there is an additional increase of 12% in the number of completed Level II evaluations returned by the contractor. It is projected that the volume of Level II evaluations will rise significantly in the future. The IT project will allow preadmission screening to be conducted as mandated and may significantly increase the number of Level II evaluations needed.

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 44% 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.

FY 2013-14	**TF**	**GF**	**FF**
Evaluations	$2,616,000	$654,000	$1,962,000
IT Project	$560,000	$140,000	$420,000
	$3,176,000	**$794,000**	**$2,382,000**

FY 2014-15	**TF**	**GF**	**FF**
Evaluations	$8,000,000	$2,000,000	$6,000,000
IT Project	$440,000	$110,000	$330,000
Ongoing M&O Costs	$150,000	$38,000	$113,000
	$8,590,000	**$2,147,000**	**$6,443,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

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:

	TF	GF	FFP
FY 2013-14	**$2,861,000**	**$1,431,000**	**$1,431,000**
FY 2014-15	**$2,861,000**	**$1,431,000**	**$1,431,000**

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:
There is no change.

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)	TF	FF
FY 2013-14	**$2,835**	**$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:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	237

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$2,400,000	$2,662,000
STATE FUNDS	$1,200,000	$1,331,000
FEDERAL FUNDS	$1,200,000	$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 2013-14			FY 2014-15		
TF	GF	FF	TF	GF	FF
$2,400	$1,200	$1,200	$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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$2,488,000	$4,815,000
STATE FUNDS	$622,000	$1,203,750
FEDERAL FUNDS	$1,866,000	$3,611,250

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 added staff required to continue updates on the CAPMAN system and incorporate CCI Duals mandated changes. An amendment has already been executed to increase funds for necessary staffing.

Methodology:
1. The contract costs will be $6,304,000 due to a contract amendment. Payments started at the beginning of August 2013.

2. Costs for FY 2013-14 will total $2,488,000 with the remaining balance of $4,815,000 being paid in FY 2014-15.

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 30

FY 2013-14:	TF	GF	FF
Contract Costs	**$2,488,000**	**$622,000**	**$1,866,000**

FY 2014-15:	TF	GF	FF
Contract Costs	**$4,815,000**	**$1,204,000**	**$3,611,000**

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	$3,000,000
STATE FUNDS	$750,000	$1,500,000
FEDERAL FUNDS	$750,000	$1,500,000

DESCRIPTION

Purpose:
This policy change estimates the infrastructure and 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 enter into a two-year contract beginning July 1, 2014, with two one-year optional extensions. Additionally, due to an increase in claims volume and stricter reporting accountability, the Department plans to provide continuous support and system upgrades to the infrastructure components, which include reporting servers, back end hardware, software and support.

Reason for Change from Prior Estimate:
The change is due to infrastructure support costs in FY 2014-15.

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. The estimated one-time infrastructure cost is $1,000,000 in FY 2014-15.

4. Assume the contractor will be hired in June 2014, and payments will begin August 2014.

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 31

FY 2013-14:	**TF**	**GF**	**FF**
Contractor cost	**$1,500,000**	**$750,000**	**$750,000**

FY 2014-15:	**TF**	**GF**	**FF**
Contractor cost	$2,000,000	$1,000,000	$1,000,000
Infrastructure cost	$1,000,000	$500,000	$500,000
Total	**$3,000,000**	**$1,500,000**	**$1,500,000**

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

	FY 2013-14	FY 2014-15
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:

	TF	GF	FF
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:	8/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1814

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$0	$2,750,000
STATE FUNDS	$0	$1,375,000
FEDERAL FUNDS	$0	$1,375,000

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:
The implementation date changed from March 2014 to August 2014.

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 $3.31 million.

3. In FY 2014-15, $2.75 million is expected to be paid. The remaining will be paid in FY 2015-16.

4. Payments will be payable in installments over a 12 month period, beginning with the Depatment approved start date of this project. The first payment is expected to be made in August 2014.

5. Premier Support invoices from the Software License Program Reseller will be payable on a monthly basis, based on actual hours worked.

	TF	GF	FF
FY 2014-15	**$ 2,750,000**	**$ 1,375,000**	**$ 1,375,000**

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

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	$338,000	$985,000
STATE FUNDS	$33,800	$98,500
FEDERAL FUNDS	$304,200	$886,500

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 August 25, 2015.

Reason for Change from Prior Estimate:
There was a delay in finalizing the contract, the completion date has been changed, and funding has been adjusted.

Methodology:
1. The following are the projected costs.

	TF	GF	FF
FY 2013-14:	**$338,000**	**$34,000**	**$304,000**

MITA

OTHER ADMIN. POLICY CHANGE NUMBER: 35

	TF	GF	FF
FY 2014-15:	**$985,000**	**$99,000**	**$886,000**

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

	FY 2013-14	FY 2014-15
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	$1,284,000	$856,000
STATE FUNDS	$642,000	$428,000
FEDERAL FUNDS	$642,000	$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 made under section 1923 of the MMA.

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:
Costs have been updated to reflect the contractor completing 1.5 audits in FY 2013-14.

Methodology:
1. Each fiscal year, all auditing activity will cost $856,000 ($428,000 GF).

2. In FY 2013-14, the contractor will complete the FY 2009-10 audit and begin the FY 2010-11 audit. The FY 2009-10 audit was originally scheduled to start in January 2013, but was delayed due to implementing the contract. The Department will make 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

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 37

for the FY 2011-12 audit.

	TF	GF	FF
FY 2013-14	**$1,284,000**	**$642,000**	**$642,000**
FY 2014-15	**$856,000**	**$428,000**	**$428,000**

Funding:
50% Title XIX / 50% GF (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

	FY 2013-14	FY 2014-15
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 acquired hardware, supplies, associated maintenance and support services that are necessary to protect and secure electronic data stored on backup systems. The data on these systems contain Medi-Cal beneficiary information that is considered confidential and/or PHI by federal and state mandates. The protection of these systems 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 enhancing infrastructure components. 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.

	TF	GF	FF
FY 2013-14:	**$750,000**	**$375,000**	**$375,000**
FY 2014-15:	**$750,000**	**$375,000**	**$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 Hospital 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

OTHER ADMIN. POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	2/2013
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 the Medi-Cal Eligibility Data System (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 submitted a Planning APD (PAPD) for the planning phase of the MEDS Modernization Project in March 2014. Project planning phase activities will continue through June 2016. Business Rules Extraction (BRE) activities will begin in May 2014 and are expected to be completed in FY 2014-15. Beginning in FY 2014-15, additional contractors will be hired to provide project planning, support, enterprise architecture, and other technical consulting services.

Reason for Change from Prior Estimate:
The scope of the project planning activities has been expanded.

Methodology:
1. For the FSR/APD contractor, the FY 2013-14 costs are based on actual payments through January 2014.

2. BRE consulting costs are estimated to be $425,000 and payments to the contractor are anticipated to begin in June 2014.

3. The FY 2014-15 costs are based on estimated costs for payments to the project planning, support, enterprise architecture, technical consulting, and BRE contractors contained in the

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER: 40

project's PAPD. Payments are expected to begin in August 2014.

FY 2013-14:	TF	GF	FF
FSR/APD	$121,000	$12,000	$109,000
Business Rules Extraction	$425,000	$42,000	$383,000
Total	**$546,000**	**$54,000**	**$492,000**

FY 2014-15:	TF	GF	FF
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
Total	**$4,533,000**	**$453,000**	**$4,080,000**

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:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	240

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$597,000	$644,000
STATE FUNDS	$298,500	$322,000
FEDERAL FUNDS	$298,500	$322,000

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/inserter machine in FY 2012-13 to automate the mailings done in-house.

Reason for Change from Prior Estimate:
Standard postage increased from $0.46 to $0.49 in January 2014. In addition, the Medi-Cal population is expected to increase in Budget Year due to expanded Medi-Cal eligibility.

Methodology:
1. The cost breakdown is shown below:

FY 2013-14	Postage	Printing	Total
Personal Injury	$180,000	$34,000	$214,000
Estate Recovery	$113,000	$249,000	$362,000
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
Total	$310,000	$285,000	$597,000

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 41

FY 2014-15	Postage	Printing	Total
Personal Injury	$194,000	$36,000	$230,000
Estate Recovery	$121,000	$272,000	$393,000
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
Total	$332,000	$310,000	$644,000

*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:

	TF	GF	FF
FY 2013-14:	**$597,000**	**$298,000**	**$299,000**
FY 2014-15:	**$644,000**	**$322,000**	**$322,000**

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

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	5/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1774

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$90,000	$836,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$90,000	$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:
Due to delays in approvals and contract, the start date changed from December 2013 to May 2014 with first records being exchanged in July 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

FY 2013-2014	**HSSF**	**FFP**	**Total**
Data Interchange Development	$10,000	$90,000	$100,000
Total	$10,000	**$90,000**	$100,000

FY 2014-2015	**HSSF**	**FFP**	**Total**
Data Provision	$279,000	$836,000	$1,115,000
Total	$279,000	**$836,000**	$1,115,000

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:
There is no change.

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,
- MDS/Options counseling training sessions, and
- LTSS MFP advisory group.

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$469,000	$325,000
STATE FUNDS	$77,900	$48,000
FEDERAL FUNDS	$391,100	$277,000

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:
The contract is being extended due to requirement changes from CMS.

Methodology:
1. The contractor began DD&I work in August 2013, and payments started in September 2013.

2. The DD&I contract duration will be extended through December 2014 to meet requirement changes.

3. M&O costs began in September 2013.

4. The current M&O contract will end in May 2014, and final payment will be made in June 2014. Assume the M&O contract will be extended for the time period of June 2014 through December 2015.

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 45

FY 2013-14:	**TF**	**GF**	**FF**
DD&I (90% FF / 10% GF)	$289,000	$29,000	$260,000
M&O			
Software (75% FF / 25% GF)	$164,000	$41,000	$123,000
Hardware (50% FF / 50% GF)	$16,000	$8,000	$8,000
Total FY 2013-14	**$469,000**	**$78,000**	**$391,000**

FY 2014-15:	**TF**	**GF**	**FF**
DD&I (90% FF / 10% GF)	$235,000	$23,000	$212,000
M&O			
Software (75% FF / 25% GF)	$82,000	$20,000	$62,000
Hardware (50% FF / 50% GF)	$8,000	$4,000	$4,000
Total FY 2014-15	**$325,000**	**$47,000**	**$278,000**

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:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1590

	FY 2013-14	FY 2014-15
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. Assume the cost of the contractor will be $400,000 in FY 2013-14 and $240,000 in FY 2014-15.

   $4,000,000 x 10% = $400,000 annual contractor cost for FY 2013-14

   $2,400,000 x 10% = $240,000 annual contractor cost for FY 2014-15

	TF	GF	FF
FY 2013-14	**$400,000**	**$ 200,000**	**$200,000**
FY 2014-15	**$240,000**	**$ 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:	7/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1615

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$216,000	$180,000
STATE FUNDS	$54,000	$45,000
FEDERAL FUNDS	$162,000	$135,000

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 June 30, 2015. 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 Invitation for Bid (IFB) and the Advance Planning Document (APD) to achieve required state and federal level approvals. The vendor will provide services through January 2015.

Reason for Change from Prior Estimate:
The change is due to delays in the project.

Methodology:
1. The estimated costs for FY 2013-14 and FY 2014-15 are:

	TF	GF	FF
FY 2013-14:	**$216,000**	**$54,000**	**$162,000**

	TF	GF	FF
FY 2014-15:	**$180,000**	**$45,000**	**$135,000**

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:
There is no change.

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.

	TF	GF	FF
FY 2013-14:	**$240,000**	**$120,000**	**$120,000**
FY 2014-15:	**$239,000**	**$119,500**	**$119,500**

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:	Randolph Alarcio
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. The report plans to be completed and submitted by June 30, 2014.

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

Methodology:
The payments to the evaluator are scheduled to continue monthly until June 30, 2014.

Funding:
50% Title XIX / 50% GF (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:
There is no change.

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:	Karen Fairgrieves
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:
1. 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:
100% 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	$111,000	$115,000
STATE FUNDS	$55,500	$57,500
FEDERAL FUNDS	$55,500	$57,500

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:
Due to 2013 and 2014 postal rate increases, the estimated expenditures have increased.

Methodology:
1. TAR postage costs for Medi-Cal are assumed to be $111,000 for FY 2013-14 based on actual expenditures (July 2013 through December 2013).

2. For FY 2014-15, the costs for TAR postage are expected to be $115,000.

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

DMHC INTER-AGENCY AGREEMENT - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	11/2013
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1815

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$158,000	$189,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$158,000	$189,000

DESCRIPTION

Purpose:
This policy change estimates the cost of 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, Statues 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:
There is a correction to the funding.

Methodology:
1. The DMHC IA was effective September 2013.

2. The reimbursement of DMHC costs began in September 2013.

3. Assume the federal share of personnel costs are $81,000 in FY 2013-14 and $97,000 in FY 2014-15.

4. Assume the federal share of operating expenses (travel, subcontracts, and training) costs are $77,000 in FY 2013-14 and $92,000 in FY 2014-15.

	Personnel Costs (FFP)	Operating Expenses (FFP)	**FFP Total**
FY 2013-14	$ 81,000	$ 77,000	**$ 158,000**
FY 2014-15	$ 97,000	$ 92,000	**$ 189,000**

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.

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:	Julie Chan
FISCAL REFERENCE NUMBER:	1453

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$62,000	$62,000
STATE FUNDS	$31,000	$31,000
FEDERAL FUNDS	$31,000	$31,000

DESCRIPTION

Purpose:
This policy change 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. On October 13, 2011, the parties began a new series of Special Master meetings to develop a plan for, and begin, settlement implementation. The court granted final approval of the proposed settlement on December 2, 2011. 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. Court jurisdiction will end December 31, 2014. The services of the special master are expected to continue through June 2015.

Reason for Change from Prior Estimate:
Special master costs are anticipated to be lower.

Methodology:
1. Assume the new Special Master costs are $124,000 for FY 2013-14 and 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

	TF	CDSS TF	DHCS TF
FY 2013-14	$124,000	$62,000	$62,000
FY 2014-15	$124,000	$62,000	$62,000

3. The Department's estimated costs for FY 2013-14 and FY 2014-15 are:

	DHCS TF	GF	FFP
FY 2013-14	**$62,000**	**$31,000**	**$31,000**
FY 2014-15	**$62,000**	**$31,000**	**$31,000**

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

Q5i AUTOMATED DATA SYSTEM ACQUISTION

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	$63,000	$59,000
STATE FUNDS	$31,500	$29,500
FEDERAL FUNDS	$31,500	$29,500

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 supports quality control efforts for federally mandated programs. As a result of implementation of the Affordable Care Act, the Centers for Medicare and Medicaid Services issued guidance to states that ended previous quality control programs and implements a series of four new pilot programs to be conducted over federal fiscal years 2014 – 2016. Q5i will need to be modified to accommodate the new federal requirements over this three year period. A contract is required for maintenance and system support costs.

Reason for Change from Prior Estimate:
Updated expenditures associated with the modifications necessary to accommodate new federal requirements.

Methodology:
1. Ongoing costs began in March 2012.

2. These estimates are provided by the vendor.

	FY 2013-14			FY 2014-15		
	TF	GF	FF	TF	GF	FF
Ongoing Cost	$63,000	$31,500	$31,500	$59,000*	$29,500	$29,500

*Rounded

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

RECOVERY AUDIT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	4/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1740

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$1,000	$12,000
STATE FUNDS	$500	$6,000
FEDERAL FUNDS	$500	$6,000

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 due to a delay in implementation.

Methodology:
1. Assume annual overpayment savings identified within the first year of program implementation are:

$12,506,375 x 1% = $125,064

2. The cost of identifying overpayments is 12.5% of the amount recovered. Underpayments are not anticipated for CY or BY.

Annual costs: $125,064 x 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 April 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 April 2014 and an additional $109 each month thereafter.

5. Estimated payments based on a cash basis are:

	TF	GF	FF
FY 2013-14	**$1,000**	**$500**	**$500**
FY 2014-15	**$12,000**	**$6,000**	**$6,000**

Funding:
50% Title XIX FFP / 50% GF (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	$23,029,000
STATE FUNDS	$0	$6,620,000
FEDERAL FUNDS	$0	$16,409,000

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 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 policy change has been updated with updated expenditures.

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 $16,143,000 for Regular DMC services and $393,000 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).

Regular DMC	FY 2011-12 County Admin	Growth		Projected County Admin Costs for FY 2014-15
Narcotic Treatment Program	$7,700,000	FY 2012-13	10%	$8,470,000
		FY 2013-14	10%	$9,317,000
		FY 2014-15	10%	$10,249,000
Intensive Outpatient Treatment	$2,368,000	FY 2012-13	10%	$2,605,000
		FY 2013-14	10%	$2,866,000
		FY 2014-15	10%	$3,153,000
Outpatient Drug Free Treatment	$6,075,000	FY 2012-13	10%	$6,683,000
		FY 2013-14	10%	$7,351,000
Residential Treatment		FY 2014-15	10%	$8,086,000
				$4,332,000
Total for FY 2014-15 (Regular)	$16,143,000	FY 2012-13	10%	$17,758,000
		FY 2013-14	10%	$19,534,000
		FY 2014-15	10%	$25,820,000

Perinatal DMC	FY 2011-12 County Admin	Growth		Projected County Admin Costs for FY 2014-15
Narcotic Treatment Program	$31,000	FY 2012-13	10%	$34,000
		FY 2013-14	10%	$37,000
		FY 2014-15	10%	$41,000
Intensive Outpatient Treatment	$118,000	FY 2012-13	10%	$130,000
		FY 2013-14	10%	$143,000
		FY 2014-15	10%	$157,000
Residential Treatment Program	$168,000	FY 2012-13	10%	$185,000
		FY 2013-14	10%	$204,000
		FY 2014-15	10%	$224,000
Outpatient Drug Free	$76,000	FY 2012-13	10%	$84,000
		FY 2013-14	10%	$92,000

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 58

		FY 2014-15	10%	$101,000
Total for FY 2014-15 (Perinatal)	$393,000	FY 2012-13	10%	$433,000
		FY 2013-14	10%	$476,000
		FY 2014-15	10%	$523,000
Total for FY 2014-15				$26,343,000

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.

	Estimated County Admin	County Funds	Title XIX	Title XXI	GF
Regular DMC	$25,820,000	$3,207,000	$16,019,000	$89,000	$6,505,000
Perinatal DMC	$523,000	$107,000	$289,000	$12,000	$115,000
Total FY 2014-15	$26,343,000	$3,314,000	**$13,308,000**	**$101,000**	**$6,620,000**

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:	Raman Pabla
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 costs for NHSP inpatient and outpatient hearing screens, the diagnostic hearing evaluations, and medical interventions are 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:
There is no 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
Total for FY 2014-15	**$4,136,000**

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:	9/2014
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.

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.

Reason for Change from Prior Estimate:
The implementation date changed to September 2014.

Methodology:
1. Assume settlement of the current litigation enjoining the law is finalized prior to July 1, 2014.

2. Assume the contractors costs will be $1,000,000 TF ($500,000 GF) annually, beginning September 1, 2014.

RATE STUDIES FOR MAIC AND AAC VENDOR

OTHER ADMIN. POLICY CHANGE NUMBER: 60

3. Estimated contractors' costs are:

	FY 2014-15
Project Management Contractor	$ 270,000
MAIC/AAC Vendor Contractor	$ 730,000
Total	**$ 1,000,000**

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$252,272,000	$264,886,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$252,272,000	$264,886,000

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.

FY 2013-14	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$408,680,000	$204,340,000	$204,340,000
CMIPS II	$95,864,000	$47,932,000	$47,932,000
Total	$504,544,000	**$252,272,000**	$252,272,000

FY 2014-15	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$466,200,000	$233,100,000	$233,100,000
CMIPS II	$63,572,000	$31,786,000	$31,786,000
Total	$529,772,000	**$264,886,000**	$264,886,000

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	$216,528,000	$223,024,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$216,528,000	$223,024,000

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.

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 62

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

FY 2013-14	TF	DHCS FFP	CDSS GF/ County Match
CWS	$233,784,000	$116,892,000	$116,892,000
CWS/CMS	$9,990,000	$4,995,000	$4,995,000
CSBG/APS	$189,282,000	$94,641,000	$94,641,000
TOTAL	$433,056,000	**$216,528,000**	$216,528,000

FY 2014-15	TF	DHCS FFP	CDSS GF/ County Match
CWS	$240,798,000	$120,399,000	$120,399,000
CWS/CMS	$10,290,000	$5,145,000	$5,145,000
CSBG/APS	$194,960,000	$97,480,000	$97,480,000
TOTAL	$446,048,000	**$223,024,000**	$223,024,000

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

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/1997
ANALYST:	Raman Pabla
FISCAL REFERENCE NUMBER:	243

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$39,021,000	$32,240,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$39,021,000	$32,240,000

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

FY 2013-14		DHCS FFP	CDDS GF	IA #
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.	$11,267,000	$11,267,000	01-15834
4	RC Medicaid Admin.	$8,581,000	$2,860,000	03-75734
5	NHR Admin.	$143,000	$143,000	03-75285
6	TCM HQ Admin.	$398,000	$398,000	03-75284
	TCM RC Admin.	$4,810,000	$4,810,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$39,021,000**	$32,499,000	

FY 2014-15		DHCS FFP	CDDS GF	IA #
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.	$10,217,000	$10,217,000	01-15834
4	RC Medicaid Admin.	$8,750,000	$2,917,000	03-75734
5	NHR Admin.	$177,000	$177,000	03-75285
6	TCM HQ Admin.	$330,000	$330,000	03-75284
	TCM RC Admin.	$4,779,000	$4,779,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$32,240,000**	$22,689,000	

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	$25,870,000	$27,503,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$25,870,000	$27,503,000

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 updated actual data.

Methodology:
1. The Department claims Title XIX federal funds with Certified Public Expenditures (CPE) from local agencies.
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, $4,272,000 for FY 2012-13 and $14,793,000 for FY 2013-14.

4. The FY 2014-15 budgeted amounts include $2,848,000 for FY 2012-13 and $9,862,000 for FY 2013-14, and $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	$2,811	$2,400	07-65592
CPSP, PCG & SOW	$21,868	$15,322	
AFLP	$1,191	$1,093	
Total	**$25,870**	$18,815	

FY 2014-15	**DHCS FFP**	**County Match**	**IA #**
BIH	$3,227	$2,752	07-65592
CPSP, PCG & SOW	$22,853	$16,298	
AFLP	$1,423	$1,316	
Total	**$27,503**	$20,366	

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:	Randolph Alarcio
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 Public Safety Realignment Initiative (Realignment) provides for a shift of responsibilities for the HCPCFC to local control under county welfare departments. Vehicle License Fund and Sales Tax

HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 65

revenues, which fund the state share of the program, will be transferred to the counties. To enable this transition, SB 1013 provides continuing funding for the existing HCPCFC model for local CHDP programs to staff the HCPCFC with CHDP nursing staff through June 30, 2015. CDSS will redirect funds for this purpose from the newly established Local Revenue Fund of 2011. CDSS is developing a timeline that will result in the transition of the HCPCFC to full local control under the county welfare departments, effective July 1, 2015.

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

Methodology:
1. CDSS provides the annual Local Revenue Fund of $8,381,000.

	DHCS FFP	Local Revenue Fund
FY 2013-14	**$25,143,000**	$8,381,000

	DHCS FFP	Local Revenue Fund
FY 2014-15	**$25,143,000**	$8,381,000

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	$31,598,000	$30,928,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$31,598,000	$30,928,000

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 provided by CDSS.

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 66

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

FY 2013-14	TF	DHCS FFP	CDSS GF
IHSS PCSP	$11,906,000	$5,953,000	$5,953,000
IHSS Health Related	$58,000	$29,000	$29,000
CWS/CMS for Medi-Cal	$536,000	$268,000	$268,000
IHSS Plus Option Sec. 1915(j)	$5,684,000	$2,842,000	$2,842,000
SAWS	$406,000	$203,000	$203,000
Medi-Cal State Hearings	$17,766,000	$8,883,000	$8,883,000
Public Inquiry and Response	$274,000	$137,000	$137,000
Medicaid Disability Evaluation Services	$26,272,000	$13,136,000	$13,136,000
Licensing Related Activities for Mental Health Facilities	$294,000	$147,000	$147,000
TOTAL	$63,196,000	**$31,598,000**	$31,598,000

FY 2014-15	TF	DHCS FFP	CDSS GF
IHSS PCSP	$15,998,000	$7,999,000	$7,999,000
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	$482,000	$241,000	$241,000
Medi-Cal State Hearings	$11,672,000	$5,836,000	$5,836,000
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
TOTAL	$61,856,000	**$30,928,000**	$30,928,000

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$19,012,000	$17,534,000
STATE FUNDS	$2,780,000	$2,533,000
FEDERAL FUNDS	$16,232,000	$15,001,000

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
- Center for Health Statistics and Informatics
- 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 for the Childhood Lead Prevention Program and Office of AIDS.

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	$366,000	$0	$366,000	$0
Childhood Lead Prevention Program	$1,608,000	$0	$0	$1,608,000
Center for Health Statistics and Informatics	$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
Total	**$16,232,000**	**$2,780,000**	$2,268,000	$10,906,000

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	$373,000	$0	$373,000	$0
Childhood Lead Prevention Program	$1,512,000	$0	$0	$1,512,000
Center for Health Statistics and Informatics	$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
Total	**$15,001,000**	**$2,533,000**	$2,275,000	$9,915,000

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$7,400,000	$5,200,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$7,400,000	$5,200,000

DESCRIPTION

Purpose:
This 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:
There is no change from prior estimate.

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)

FY 2013-14	**DHCS FFP**	**CDPH CLPP Fee Funds**
Administrative Costs	**$7,400**	$7,400

FY 2014-15	**DHCS FFP**	**CDPH CLPP Fee Funds**
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:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1748

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$6,832,000	$6,130,000
STATE FUNDS	$2,698,700	$2,421,350
FEDERAL FUNDS	$4,133,300	$3,708,650

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.

Beginning January 1, 2014, the Department instructed MAXIMUS to close out the Single Point of Entry (SPE) application services and to refer applicants to use the application portal and toll-free line at Covered California. The shutdown process will be completed in FY 2013-14.

Beginning November 1, 2013, the Access for Infants and Mothers (AIM) infants above the 250% of poverty level transitioned into the Medi-Cal program. The transition ended on February 1, 2014.

Beginning July 1, 2014, the AIM mothers will transition into the Medi-Cal program.

SINGLE POINT OF ENTRY - MEDI-CAL ONLY

OTHER ADMIN. POLICY CHANGE NUMBER: 69

Reason for Change from Prior Estimate:
Actual HFP data through February 2014 was incorporated into the caseload projections which showed a decrease. The close out of the SPE is occurring in FY 2013-14. Two new AIM populations are being added to the estimate.

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.

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.

FY 2013-14	**GF**	**FF**	**TF**
Call Minute Rate per Minute	$2,122,000	$3,250,000	$5,372,000
Transaction Forwarding Fee	$577,000	$883,000	$1,460,000
Total	$2,699,000	$4,133,000	**$6,832,000**

FY 2014-15	**GF**	**FF**	**TF**
Call Minute Rate per Minute	$1,896,000	$2,903,000	$4,799,000
Transaction Forwarding Fee	$526,000	$805,000	$1,331,000
Total	$2,422,000	$3,708,000	**$6,130,000**

*Amounts differ due to rounding

Funding:

FY 2013-14	**GF**	**FF**	**TF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$1,025,000	$1,025,000	$2,050,000
65% Title XXI / 35% GF (4260-113-0890/0001)	$1,674,000	$3,109,000	$4,782,000
FY 2014-15			
50% Title XIX / 50% GF (4260-101-0890/0001)	$920,000	$920,000	$1,839,000
65% Title XXI / 35% GF (4260-113-0890/0001)	$1,502,000	$2,789,000	$4,291,000

*Amounts differ due to rounding

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	7/1984
ANALYST:	Davonna McClendon
FISCAL REFERENCE NUMBER:	253

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$3,129,000	$3,523,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,129,000	$3,523,000

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:
Estimated projections were updated by CDA.

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	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2012-13 DOS	$10	$12		
FY 2013-14 DOS	$1,483	$1,715	$46	$53
FY 2014-15 DOS			$1,484	$1,770
Total CBAS	$1,493	$1,727	$1,530	$1,823
MSSP Support				
FY 2012-13 DOS	$8	$9		
FY 2013-14 DOS	$1,203	$1,393	$37	$43
FY 2014-15 DOS			$1,195	$1,382
Total MSSP	$1,211	$1,402	$1,232	$1,425
ADRC Support*				
FY 2014-15 DOS				$275
Grand Total	$2,705	**$3,129**	$2,762	**$3,523**

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$1,028,000	$946,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,028,000	$946,000

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 technical assistance, training, and an evaluation component for grantees.

The CDPH budgets the I&E program under the Maternal, Child and Adolescent Health Division.

Reason for Change from Prior Estimate:
Expenditures decrease due to budget reductions.

Methodology:
1. CDPH budgets the non-federal matching funds.

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 71

2. CDPH provides the estimated costs on a cash basis.

	TF	CDPH GF	DHCS FF
FY 2012-13	$732,000	$366,000	$366,000
FY 2013-14	$1,324,000	$662,000	$662,000
Total FY 2013-14	$2,056,000	$1,028,000	**$1,028,000**

	TF	CDPH GF	DHCS FF
FY 2013-14	$568,000	$284,000	$284,000
FY 2014-15	$1,324,000	$662,000	$662,000
Total FY 2014-15	$1,892,000	$946,000	**$946,000**

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	$1,197,000	$1,197,000
STATE FUNDS	$1,197,000	$1,197,000
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 covered 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. Select adult optional dental services will be reinstated May 1, 2014.

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 $1,197,000 annually.
4. All costs are reimbursed by CDDS.

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 2014-15 and FY 2015-16, of these 46% of the kits are expected to be distributed to Medi-Cal eligible newborns.

   370,000 kits x 46% = 170,200 Medi-Cal kits

2. Approximately 51% of the kits distributed will be basic kits and 49% will be custom kits.

   170,200 Medi-Cal kits x 51% = 86,802 basic kits
   170,200 Medi-Cal kits x 49% = 83,398 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 2013-14 will be paid in FY 2014-15 and $501,000 for FY 2014-15 will be paid in FY 2015-16.

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	$1,002,000
Total FY 2012-13 Cost	**$2,034,000**

Cash Basis	**FY 2013-14**	**FY 2014-15**
FY 2012-13	$501,000	$0
FY 2013-14	$1,533,000	$501,000
FY 2014-15	$0	$1,533,000
Total:	$2,034,000	$2,034,000
FFP Total:	**$1,017,000**	**$1,017,000**

Funding:
100% Title XIX 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	$1,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,000,000	$1,000,000

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) 13-90417

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 because the IA limits the annual amount to be $1,000,000 provided to CDPH.

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:
100% Title XIX 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

FY 2013-14	TF	CDVA GF	DHCS FF
Administrative	$436,000	$218,000	$218,000
Workload Units	$1,476,000	$738,000	$738,000
Total	$1,912,000	**$956,000**	$956,000

FY 2014-15	TF	CDVA GF	DHCS FF
Administrative	$436,000	$218,000	$218,000
Workload Units	$1,476,000	$738,000	$738,000
Total	$1,912,000	**$956,000**	$956,000

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:
1. 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.

Cash Basis	DHCS FF	CHHS GF
FY 2013-14:	**$651,000**	$651,000
FY 2014-15:	**$651,000**	$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

	FY 2013-14	FY 2014-15
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 that meet current state regulations, so the Merit System Services Program was established under the State Personnel Board and is now administered by the CalHR to administer personnel services for the counties that do not have one. In addition, the CalHR reviews the merit systems in the remaining 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:
There is no change.

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 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:
There is no change.

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:

	TF	CDPH GF	DHCS FF
FY 2011-12 expenditures	$106,000	$53,000	$53,000
Total FY 2013-14	$106,000	$53,000	**$53,000**

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	$380,000	$440,000
STATE FUNDS	$190,000	$220,000
FEDERAL FUNDS	$190,000	$220,000

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:
Transition of Healthy Families and Low Income Health Plan populations as well as Medicaid expansion resulting from ACA.

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 and rates.

3. Based on the transition of children from the Healthy Families Program to the Medi-Cal Program, PIA anticipates a total of 588,000 Medi-Cal jobs (RX orders). PIA shipments average 2.44 Medi-Cal jobs per package which equates to 241,000 shipments (588,000/2.44). Much of the increase was observed in the later part of calendar year 2013.

   The cost for FY 2013-14 is estimated to be: $1.625 x 1.04 x 241,000 = $407,000 TF for FY 2013-14.

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 79

4. Expect a continued trend upward due to ACA expansion and increase in utilization in FY 2014-15. Estimated shipped packages are 260,000 in FY 2014-15.

   The cost for FY 2014-15 is estimated to be: $1.625 x 1.04 x 260,500 = $440,000 TF.

5. There is a one quarter lag for the payment of these services.

Cash Basis	**FY 2013-14**	**FY 2014-15**
FY 2012-13 Services	$83,000	$0
FY 2013-14 Services	$297,000	$110,000
FY 2014-15 Services	$0	$330,000
Budget Year Total	**$380,000**	**$440,000**

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

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$250,000	$0
STATE FUNDS	$125,000	$0
FEDERAL FUNDS	$125,000	$0

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.

The Department was able to utilize an existing contract to conduct third party validation activities.

Reason for Change from Prior Estimate:
The Department does not anticipate any contract costs in FY 2014-15.

Methodology:
1. The contractor started providing services December 1, 2013.

2. The total contract cost is $500,000.

3. Assume $250,000 will be spent in FY 2013-14.

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

DENTAL FI RE-PROCUREMENT IV&V

OTHER ADMIN. POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1840

	FY 2013-14	FY 2014-15
TOTAL FUNDS	$0	$282,000
STATE FUNDS	$0	$70,500
FEDERAL FUNDS	$0	$211,500

DESCRIPTION

Purpose:
This policy change estimates the cost of an Independent Verification and Validation (IV&V) consultant to support the Dental Fiscal Intermediary Re-Procurement (DFIR) project.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
In 2011, the Centers for Medicare & Medicaid Services (CMS) determined the new dental Fiscal Intermediary (FI) contract did not meet the regulatory criteria and conditions as a Medicaid Management Information System (MMIS) acquisition, and denied enhanced federal funding. The Department plans to re-procure a new FI contract that complies with federal regulations and is eligible for enhanced federal funding. The Department plans to procure an IV&V contractor to provide project oversight and governance.

The IV&V contractor will provide management with an independent perspective on project activities and promote early detection of project/product variances. This allows the project to implement corrective actions to bring the project back in-line with agreed-upon expectations. Objectives of performing IV&V include:

- Facilitate early detection and correction of cost and schedule variances,
- Enhance management insight into process and product risk,
- Support project lifecycle process to ensure compliance with regulatory, performance, budget, and schedule requirements, and
- Validate the project's product and processes to ensure compliance with defined requirements.

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

Methodology:

1. The IV & V consultant will be hired in July 2014 and the contract will end in January 2016.

2. Total estimated costs are $446,000.

DENTAL FI RE-PROCUREMENT IV&V

OTHER ADMIN. POLICY CHANGE NUMBER: 82

	TF	GF	FF
FY 2013-14:	**$0**	**$0**	**$0**

	TF	GF	FF
FY 2014-15:	**$282,000**	**$71,000**	**$211,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

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FISCAL INTERMEDIARY ESTIMATE

May 2014

FY 2013-14	TOTAL	FEDERAL	STATE
MEDICAL FISCAL INTERMEDIARY CONTRACT (a)	$220,521,000	$160,455,000	$60,066,000
DENTAL FISCAL INTERMEDIARY CONTRACT (b)	$83,005,000	$56,523,000	$26,482,000
HEALTH CARE OPTIONS (c)	$119,301,000	$65,079,000	$54,222,000
STATE CONTROLLER/STATE TREASURER	$1,856,000	$1,147,000	$709,000
PROVIDER VERIFICATION FILE	$2,000	$1,000	$1,000
TOTAL MEDI-CAL COSTS	**$424,685,000**	**$283,205,000**	**$141,480,000**

Refugee expenditures of $119,342 are included in the Reimbursement line (4260-610-0995) in the Management Summary.

(a) Includes $361,501 TF ($126,525 GF) for Title XXI activities (4260-113-0001/0890), and $20,624,271 TF ($4,032,652 GF) for HIPAA (4260-117-0001/0890).

(b) Includes $200,000 TF ($70,000 GF) for Title XXI activities (4260-113-0001/0890), and $714,000 TF ($178,500 GF) for HIPAA (4260-117-0001/0890).

(c) Includes $23,548,000 TF ($8,242,000 GF) for Title XXI activities (4260-113-0001/0890).

FISCAL INTERMEDIARY ESTIMATE

May 2014

FY 2014-15	TOTAL	FEDERAL	STATE
MEDICAL FISCAL INTERMEDIARY CONTRACT (a)	$255,355,000	$193,147,000	$62,208,000
DENTAL FISCAL INTERMEDIARY CONTRACT (b)	$99,835,000	$68,107,000	$31,728,000
HEALTH CARE OPTIONS (c)	$135,822,000	$72,738,000	$63,084,000
STATE CONTROLLER/STATE TREASURER	$1,856,000	$1,148,000	$708,000
PROVIDER VERIFICATION FILE	$2,000	$1,000	$1,000
TOTAL MEDI-CAL COSTS	**$492,870,000**	**$335,141,000**	**$157,729,000**

Refugee expenditures of $140,531 are included in the Reimbursement line (4260-610-0995) in the Management Summary.

(a) Includes $213,775 TF ($74,821 GF) for Title XXI activities (4260-113-0001/0890), and $21,545,520 TF ($3,510,843 GF) for HIPAA (4260-117-0001/0890).

(b) Includes $460,000 TF ($115,000 GF) for HIPAA (4260-117-0001/0890).

(c) Includes $14,069,000 TF ($4,924,000 GF) for Title XXI activities (4260-113-0001/0890).

FISCAL INTERMEDIARY

Comparison of May 2014 Estimate to Appropriation and November 2013 Estimate

Current Year 2013-14 Comparison

	2013-14 Appropriation		November 2013 Estimate CY		**May 2014 Estimate CY**		Difference between May 2014 & Appropriation		Difference between May 2014 & November 2013	
	Total Funds	**State Funds**	**Total Funds**	**State Funds**	**Total Funds**	**State Funds**	**Total Funds**	**State Funds**	**Total Funds**	**State Funds**
Xerox Medical Fiscal Intermediary	$180,393,000	$49,650,000	$207,931,000	$56,225,000	$220,521,000	$60,066,000	$40,128,000	$10,416,000	$12,590,000	$3,841,000
Total Dental Fiscal Intermediary	$74,158,000	$23,631,000	$82,337,000	$26,222,000	$83,005,000	$26,482,000	$8,847,000	$2,851,000	$668,000	$260,000
Total Health Care Options	$96,787,000	$48,643,000	$122,126,000	$58,369,000	$119,301,000	$54,222,000	$22,514,000	$5,579,000	($2,825,000)	($4,147,000)
Total Miscellaneous Expenditures	$1,858,000	$709,000	$1,858,000	$710,000	$1,858,000	$710,000	$0	$1,000	$0	$0
Reconciliation with Budget Act	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
GRAND TOTAL	**$353,196,000**	**$122,633,000**	**$414,252,000**	**$141,526,000**	**$424,685,000**	**$141,480,000**	**$71,489,000**	**$18,847,000**	**$10,433,000**	**-$46,000**

Budget Year 2013-14 Comparison

	November 2013 Estimate BY		**May 2014 Estimate BY**		Difference between May 2014 & November 2013	
	Total Funds	**State Funds**	**Total Funds**	**State Funds**	**Total Funds**	**State Funds**
Xerox Medical Fiscal Intermediary	$250,541,000	$60,828,000	$255,355,000	$62,208,000	$4,814,000	$1,380,000
Total Dental Fiscal Intermediary	$88,707,000	$28,367,000	$99,835,000	$31,728,000	$11,128,000	$3,361,000
Total Health Care Options	$78,164,000	$37,403,000	$135,822,000	$63,084,000	$57,658,000	$25,681,000
Total Miscellaneous Expenditures	$1,858,000	$709,000	$1,858,000	$709,000	$0	$0
GRAND TOTAL	**$419,270,000**	**$127,307,000**	**$492,870,000**	**$157,729,000**	**$73,600,000**	**$30,422,000**

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 and Consultant 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
May 2014

FY 2013-14	Total Funds	State Funds
Operations	$99,010,424	$32,307,745
Hourly Reimbursement	$22,521,348	$5,400,406
Cost Reimbursement	$27,982,435	$8,526,731
Other Estimated Costs	$18,751,928	$4,800,377
Change Orders	$7,872,096	$2,040,676
Healthy Families (XXI)	$361,501	$126,525
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	$214,705,900	$58,612,310
Sales Tax	$5,814,997	$1,453,749
TOTAL MEDICAL FI COSTS	**$220,520,897**	**$60,066,059**

FY 2014-15	Total Funds	State Funds
Operations	$94,725,730	$30,885,228
Hourly Reimbursement	$17,237,448	$4,142,502
Cost Reimbursement	$25,195,483	$7,043,261
Other Estimated Costs	$33,687,282	$6,753,464
Change Orders	$608,702	$241,851
Healthy Families (XXI)	$213,775	$74,821
Enhancements	$17,318,756	$2,074,787
System Replacements	$60,740,842	$9,554,535
Family PACT	$125,000	$62,500
Sub-Total	$249,853,018	$60,832,947
Sales Tax	$5,501,827	$1,375,457
TOTAL MEDICAL FI COSTS	**$255,354,845**	**$62,208,404**

MEDICAL FISCAL INTERMEDIARY ESTIMATE (DETAIL TABLE)
May 2014

FY 2013-14	TOTAL FUNDS
OPERATIONS	**$99,010,424**
General ACLs	$65,905,575
On-Line Pharmacy ACLs	$4,418,002
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
HOURLY REIMBURSEMENT	**$22,521,348**
Systems Group	$21,969,900
Field Office Automation Group (FOAG)	$551,448
COST REIMBURSEMENT	**$27,982,435**
Postage	$2,421,335
Parcel Services & Common Carriers	$144,102
Equipment/Services	$6,635,536
P&D and PUBS	$2,494,514
Other Direct Costs	$1,437,978
Facilities Improve/Modif	$2,712,400
Audits & Research	$225,720
Change Orders	$123,940
Consultant Contracts	$5,268,074
Telecommunication	$2,356,640
Other Cost Reimburseable Items	$4,162,196
OTHER ESTIMATED COSTS	**$18,751,928**
Beneficiary ID Cards - BIC	$1,500,000
Health Access Program Cards	$320,000
Provision 11 & 57	$1,493,224
RAIS Medi-Cal	$1,300,000
RAIS MCO	$3,000,000
Cost Containment	$3,100,000
Fixed PrIce Billable SG	$8,038,704
CHANGE ORDERS	**$7,872,096**
Negotiated Change Orders	$6,416,171
Change Orders in Progress	$1,455,925
Unspecified Change Orders	$0

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CY Medical FI Estimate (Detail Table), November 2013 Estimate
Continued from Page 8

FY 2013-14	TOTAL FUNDS
ENHANCEMENTS	**$12,225,809**
HIPAA 5010	$4,814,200
HIPAA ICD-10	$3,302,383
BRE	$4,109,226
OPTIONAL CONTRACTUAL SERVICES	**$3,217,301**
HITECH	$3,217,301
SYSTEM REPLACEMENTS	**$22,638,058**
HEALTHY FAMILIES (Title XXI only)	**$361,501**
FAMILY PACT	**$125,000**
SUBTOTAL	**$214,705,900**
SALES TAX 8%	$5,814,997
MEDICAL FI TOTAL FUND	**$220,520,897**

MEDICAL FISCAL INTERMEDIARY ESTIMATE (DETAIL TABLE
May 2014

FY 2014-15	TOTAL FUNDS
OPERATIONS	**$94,725,730**
General ACLs	$62,264,685
On-Line Pharmacy ACL s	$4,344,198
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
HOURLY REIMBURSEMENT	**$17,237,448**
Systems Group	$16,686,000
Field Office Automation Group (FOAG)	$551,448
COST REIMBURSEMENT	**$25,195,483**
Postage	$2,410,628
Parcel Services & Common Carriers	$135,371
Equipment/Services	$6,358,147
P&D and PUBS	$2,487,059
Other Direct Costs	$1,230,670
Facilities Improve/Modif	$0
Audits & Research	$0
Change Orders	$276,614
Consultant Contracts	$6,940,777
Telecommunication	$2,276,255
Other Cost Reimburseable Items	$3,079,962
OTHER ESTIMATED COSTS	**$33,687,282**
Beneficiary ID Cards - BIC	$1,500,000
Health Access Program Cards	$270,000
Provision 11 & 57	$1,924,283
RAIS Medi-Cal	$1,700,000
RAIS MCO	$3,000,000
Cost Containment	$3,100,000
Fixed PrIce Billable SG	$22,192,999
CHANGE ORDERS	**$608,702**
Negotiated Change Orders	$358,702
Change Orders in Progress	$250,000
Unspecified Change Orders	$0

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CY Medical FI Estimate (Detail Table), November 2013 Estimate
Continued from Page 10

FY 2014-15	TOTAL FUNDS
ENHANCEMENTS	**$17,318,756**
HIPAA 5010	$0
HIPAA ICD-10	$13,209,530
BRE	$4,109,226
SYSTEM REPLACEMENTS	**$60,740,842**
HEALTHY FAMILIES (TITLE XXI ONLY)	**$213,775**
FAMILY PACT	**$125,000**
SUBTOTAL	**$249,853,018**
SALES TAX 8%	$5,501,827
MEDICAL FI TOTAL FUND	**$255,354,845**

Assumptions

ACL Projections:

FY 2013-14

	General ACLs	Amount	Online-Drug ACLs	Amount
Total ACLs	161,118,487	$66,243,467	33,801,589	$4,441,611
Less HFP	784,649	$337,892	174,459	$23,609
Total Medi-Cal ACLs	**160,333,838**	**$65,905,575**	**33,627,129**	**$4,418,002**

Based on the estimated FY 2013-14 volumes, general ACLs are projected at $0.41432 and online ACLs are projected at $0.13161. 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

	General ACLs	Amount	Online-Drug ACLs	Amount
Total ACLs	198,000,681	$62,460,394	32,869,132	$4,362,264
Less HFP	745,171	$195,709	175,198	$18,066
Total Medi-Cal ACLs	**197,255,510**	**$62,264,685**	**32,693,934**	**$4,344,198**

Based on the estimated FY 2014-15 volumes, general ACLs are projected at $0.31997 and online ACLs are projected at $0.13428. 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

Change Order No.	Title/Description	Effective
9	**Telephone Services Center Rate Adjustment for Contract Year 1**	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).

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$742,388	$0
General Funds	$215,478	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$742,388	$0
General Funds	$215,478	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
11	**Encounter Claim Line BVMP for Contract Year 1**	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).

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$212,704	$0
General Funds	$53,176	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$212,704	$0
General Funds	$53,176	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
12	**Diagnosis Related Groups**	10/31/2013

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.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$466,841	$358,702
General Funds	$233,421	$179,351
Cost Reimbursement:		
Total Funds	$123,940	$276,614
General Funds	$61,970	$138,307
Total Funds	$590,781	$635,316
General Funds	$295,391	$317,658

Negotiated Change Orders

Change Order No.	Title/Description	Effective
14	**MITA 2.0 to 3.0 Gap Analysis**	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.

	FY 2013-14	**FY 2014-15**
Change Order Administration:		
Total Funds	$55,075	$0
General Funds	$13,769	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$55,075	$0
General Funds	$13,769	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
15	**Encounter Claim Lines BVMP for Contract Year 2 (Phase I)**	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).

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$179,481	$0
General Funds	$44,870	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$179,481	$0
General Funds	$44,870	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
17	**Rebate Accounting and Information System for MCO for Contract Year 1**	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.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$1,404,313	$0
General Funds	$351,078	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$1,404,313	$0
General Funds	$351,078	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
18	**Rebate Accounting and Information System for MCO for Contract Year 2 (Phase I)**	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.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$2,672,087	$0
General Funds	$668,022	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$2,672,087	$0
General Funds	$668,022	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
19	**Encounter Claim Lines BVMP for Contract Year 2 (Phase II)**	10/2/2013

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 last 6 months of Contract Year 2 (January 1, 2013 through June 29, 2013).

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$203,282	$0
General Funds	$50,821	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$203,282	$0
General Funds	$50,821	$0

Negotiated Change Orders

Change Order No.	Title/Description	Effective
22	**Payment for the Processing of External Medicaid Related Applications**	12/20/2013

The current Fiscal Intermediary Contract 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 (CO) process. As a result of changes promulgated by the enactment of the Patient Protection and Affordable Care Act (ACA), Xerox processed Medicaid related applications received from Covered California. This work is not required in the Contract. This CO compensates Xerox for the processing of Medicaid related applications. Compensation includes reimbursement to Xerox for hourly wages for Key Data Entry (KDE) staff and manager or supervisors overseeing the processing of applications. The work was completed in February of 2014.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$240,000	$0
General Funds	$0	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Interagency Agreement:		
Total Funds	$240,000	$0
General Funds	$0	$0
Total Funds	$240,000	$0
General Funds	$0	$0
Interagency Agreement	$240,000	

Negotiated Change Orders

Change Order No.	Title/Description	Effective
23	**Payment for the Processing of External Medicaid Related Surplus Applications**	3/17/2014

The current Fiscal Intermediary Contract 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 (CO) process. As a result of changes promulgated by the enactment of the Patient Protection and Affordable Care Act (ACA), Xerox processed Medicaid related applications received from Covered California. This work is not required in the Contract. This CO compensates Xerox for the processing of surplus Medicaid related applications. Compensation includes reimbursement to Xerox for hourly wages for Key Data Entry (KDE) staff and manager or supervisors overseeing the processing of applications, which is expected to be completed by the end of April of 2014.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$240,000	$0
General Funds	$0	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Interagency Agreement:		
Total Funds	$240,000	$0
General Funds	$0	$0
Total Funds	$240,000	$0
General Funds	$0	$0
Interagency Agreement	$240,000	

Change Orders in Progress

Change Order No.	Title/Description	Effective
16	**Telephone Services Center Rate Adjustment for Contract Year 2**	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).

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$1,144,367	$0
General Funds	$332,153	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$1,144,367	$0
General Funds	$332,153	$0

Change Orders in Progress

Change Order No.	Title/Description	Effective
20	**Rebate Accounting and Information System for MCO for Contract Year 2 (Phase II)**	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.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$311,558	$0
General Funds	$77,890	$0
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$311,558	$0
General Funds	$77,890	$0

Change Orders in Progress

Change Order No.	Title/Description	Effective
21	**AB97 Erroneous Payment Corrections**	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.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$0	$250,000
General Funds	$0	$62,500
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$0	$250,000
General Funds	$0	$62,500

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, prophylaxsis, 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
May 2014

FY 2013-14

	Total Fund	General Fund
Dental Administration/Operations	$45,393,000	$12,522,794
Telephone Service Center	$15,930,000	$6,730,425
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	$900,000	$225,000
Contract Takeover	$907,000	$226,750
Total Dental Administration Costs	**$83,005,200**	**$26,482,269**

Dental Fiscal Intermediary
May 2014

FY 2014-15

	Total Fund	General Fund
Dental Administration Operations	$60,862,446	$17,041,635
Telephone Service Center	$17,790,000	$7,516,275
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	$775,000	$193,750
Total Dental Administration Costs	**$99,835,146**	**$31,727,585**

DENTAL COST REIMBURSABLE EXPENSES

May 2014

	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
Total	**$6,069,000**	**$2,913,000**	**$6,069,000**	**$2,913,000**

DENTAL FISCAL INTERMEDIARY
ACSL & TAR PROJECTIONS

May 2014

FY 2013-14 Assumptions

➢ ACSL Projections:	30,063,647	$39,136,000
➢ TAR Projections:	328,042	$6,257,000
		$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	$6,647,000
		$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

Change Order No.	Title/ Description	Effective
7	***Conlan, Schwarzmer, Stevens vs. Bontá***	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.

	FY 2013-14	**FY 2014-15**
Total Funds	$100,000	$100,000
General Funds	$50,000	$50,000

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
9	**Health Insurance Portability and Accountability Act (HIPAA) Addendum - Security Risk Assessment**	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.

	FY 2013-14	**FY 2014-15**
Total Funds	$300,000	$310,000
General Funds	$75,000	$77,500

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
23	**Federal Rule – Revalidation of Provider Enrollment**	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 work towards compliance, the Department has hired additional FI staff to complete the increased workload. The change order was approved in May 2013 and became effective June 2013. The FI recruited additional staff and started incurring costs beginning October 2013.

	FY 2013-14	**FY 2014-15**
Total Funds	$1,281,000	$1,438,000
General Funds	$640,500	$719,000

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
24	**Federal Rule – Database Checks**	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 work towards compliance, the Department has hired additional FI staff to complete the increased workload. The change order was approved in May 2013 and became effective June 2013. The FI recruited additional staff and started incurring costs beginning October 2013.

	FY 2013-14	**FY 2014-15**
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 3 Two-Plan and Regional Expansion 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
May 2014
FY 2013-14

CONTRACT NO. 07-65829:

			Total Fund	General Fund
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 Questionaire (MET/HIF)	$165,115		
	CCI Booklets - Incremental Costs	$634,759		
	Base Volume Increase Projection	$5,728,833		
	Prior year unpaid invoices (April & May)	$8,309,967		
	Total Operations		$37,606,235	$18,803,118
Hourly Reimbursement:				
Section 8.6	Enrollment Services Representatives		$12,407,722	$6,203,861
Cost Reimbursement				
Section 8.7	Various		$31,078,788	$15,539,394
Personalized Provider Directories (PPD)			($2,000,000)	($1,000,000)
Transition of Duals Eligible - Long-Term Care Savings			$10,206,527	$5,103,264
Transition of Healthy Families Children to Medi-Cal Admin. Costs			$11,618,067	$4,066,323
Low Income Health Program (LIHP) Implementation			$10,724,472	$5,362,236
Managed Care Expansion to Rural Counties			$7,224,489	$3,612,245
Beneficiary Dental Exception (BDE)			$90,876	$45,438
ACA Express Lane Enrollment			$3,606,800	$1,803,400
Change Order #3			($3,262,835)	($1,141,992)
Operations Allocation at FFP 65/35			$0	($4,175,540)
TOTAL HEALTH CARE OPTIONS FY 2013-14 ESTIMATE			**$119,301,141**	**$54,221,746**

HEALTH CARE OPTIONS
May 2014
FY 2014-15

CONTRACT NO. 07-65829:

			Total Fund	General Fund
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 Questionaire (MET/HIF)	$169,242		
	CCI Booklets - Incremental Costs	$930,980		
	Base Volume Increase Projection	$13,749,199		
	Prior year unpaid invoices (April & May)	$0		
	Total Operations		$38,400,315	$19,200,158
Hourly Reimbursement:				
Section 8.6	Enrollment Services Representatives		$13,373,388	$6,686,694
Cost Reimbursement:				
Section 8.7.1	Various		$32,677,168	$16,338,584
Personalized Provider Directories (PPD)			($2,000,000)	($1,000,000)
Transition of Duals Eligible - Long-Term Care Savings			$37,506,554	$18,753,277
Transition of Healthy Families Children to Medi-Cal Admin Costs			$486,451	$170,258
Low Income Health Program (LIHP) Implementation			$1,425,702	$712,851
Managed Care Expansion to Rural Counties			$3,772,533	$1,886,267
Beneficiary Dental Exception (BDE)			$290,969	$145,485
ACA Express Lane Enrollment			$9,888,885	$4,944,443
Change Order #3			$0	$0
Operations Allocation at FFP 65/35				($4,753,769)
TOTAL HEALTH CARE OPTIONS FY 2014-15 ESTIMATE			**$135,821,965**	**$63,084,246**

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. 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. Based upon the assessment, the Department will continue implementing the pilot statewide during FY 2014-15.

	FY 2013-14	FY 2014-15
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)

Transition of Dual Eligibles - Long-Term Care Savings

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. Additional administrative costs will be required to enroll over one million beneficiaries into the CCI's Cal MediConnect Pilot and Long Term Services and Supports managed care health plans in six pilot counties phased in over twelve months. In January 2014, the Department's Health Care Options enrollment broker (broker) began mailing special informing notices, and providing information and enrollment assistance to beneficiaries through a temporary specialized call center. The broker will assist these beneficiaries in making an informed managed care health plan choice and will address questions or problems concerning their managed care health plan enrollment.

	FY 2013-14	FY 2014-15
Total Funds	$10,206,527	$37,506,554
General Funds	$5,103,264	$18,753,277

Transition of Healthy Families Children to Medi-Cal Admin Costs

Pursuant to AB 1494 (Chapter 28, Statutes of 2012) effective January 1, 2013, children subscribed in the HFP began transitioning into Medi-Cal through a phase-in methodology. The final group transitioned effective November 1, 2013. 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).

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.

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.

In December 2012, the Department began mailing written notices to beneficiaries enrolled in HFP explaining their transition to the Medi-Cal Managed Care program. The mailings continued through January 2014. 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.

	FY 2013-14	FY 2014-15
Operation Allocation	$11,930,114	$13,582,197
Healthy Family Transition	$11,618,067	$486,451
Less: Change Order #3	($3,262,835)	($0)
Total Funds	$20,285,346	$14,068,648
General Funds	$7,099,871	$4,924,027

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 transitioned into Medi-Cal managed care beginning January 1, 2014.

The Department developed notices informing beneficiaries of the transition process. Beginning November 1, 2013, approximately 600,000 notices were mailed to beneficiaries. Due to the expanded scope of the project, there will be associated costs to the State beginning in FY 2013-14 for the Health Care Options enrollment broker to mail the special notices and to provide telephone call center customer service to LIHP beneficiaries enrolling into Medi-Cal managed care.

	FY 2013-14	FY 2014-15
Total Funds	$10,724,472	$1,425,702
General Funds	$5,362,236	$712,851

Managed Care Expansion to Rural Counties

AB 1467 (Chapter 23, Statutes of 2012) expanded managed care from 30 counties 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 transition to managed care in the 28 counties began on September 1, 2013. Beneficiaries were transitioned into four different managed care models – County Organized Health Systems, Regional Model, San Benito Model, and Imperial Model.

Current fee-for-service Seniors and Persons with Disabilities (SPDs) in rural expansion counties have the option to enroll in managed care during the transition. During FY 2014-15 SPDs are expected to transition to managed care which will require the Department's Health Care Options enrollment broker (broker) to mail special informing notices, and provide information and enrollment assistance to beneficiaries. The broker will assist these beneficiaries in making an informed managed care health plan choice and will address questions or problems concerning their managed care health plan enrollment.

	FY 2013-14	FY 2014-15
Total Funds	$7,224,489	$3,772,533
General Funds	$3,612,245	$1,886,267

Beneficiary Dental Exception

AB 1467 (Chapter 23, Statues 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 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 March 11, 2014. The Department will incur additional costs for these mailings.

	FY 2013-14	FY 2014-15
Total Funds	$90,876	$290,969
General Funds	$45,438	$145,485

ACA Express Lane Enrollment

The Centers for Medicare and Medicaid Services (CMS) 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. In December 2013, CMS approved the Department's waiver to provide Express Lane Enrollment into Medi-Cal for the following groups:

- CalFresh adult and children eligibles; and
- Parents/caretaker relatives of Medi-Cal income eligible children.

On February 2, 2014, the Department's Health Care Options enrollment broker (broker) began mailing special informing notices to over 600,000 CalFresh eligible adults and children in County Organized Health Care System (COHS) and non-COHS managed care counties. The broker will assist these beneficiaries in making an informed managed care health plan choice and will address questions or problems concerning their managed care health plan enrollment. Information and assistance will be provided to this new expansion population by phone and in person through FY 2014-15.

	FY 2013-14	FY 2014-15
Total Funds	$3,606,800	$9,888,885
General Funds	$1,803,400	$4,944,443

Negotiated Change Orders

Change Order No.	Title/Description	Effective
2	**SPD Mandatory Enrollment into Managed Care HCO Costs – Special Packet Inserts**	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.

	FY 2013-14	FY 2014-15
Change Order Administration:		
Total Funds	$57,738	$63,512
General Funds	$28,869	$31,756
Cost Reimbursement:		
Total Funds	$0	$0
General Funds	$0	$0
Total Funds	$57,738	$63,512
General Funds	$28,869	$31,756

Negotiated Change Orders

Change Order No.	Title/Description	Effective
3	**Healthy Families Transition to Medi-Cal Managed Care – Special Outbound Telephone Call Campaigns/Surveys**	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.

	FY 2013-14	**FY 2014-15**
Change Order Administration:		
Total Funds	$2,771,700	$0
General Funds	$970,095	$0
Cost Reimbursement:		
Total Funds	$491,135	$0
General Funds	$171,897	$0
Total Funds	$3,262,835	$0
General Funds	$1,141,992	$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.

FY 2013-14 Estimate	Total	GF	FFP
CSCO			
Warrants & RADs	$793,617	$198,404	$595,212
Postage	$981,383	$490,692	$490,692
SCO Total	**$1,775,000**	**$689,096**	**$1,085,904**
CSTO			
Warrant Redemption	$80,652	$20,163	$60,489
TOTAL	**$1,855,652**	**$709,259**	**$1,146,393**

FY 2014-15 Estimate	Total	GF	FFP
CSCO			
Warrants & RADs	$798,750	$199,688	$599,063
Postage	$976,250	$488,125	$488,125
SCO Total	**$1,775,000**	**$687,813**	**$1,087,188**
CSTO			
Warrant Redemption	$80,652	$20,163	$60,489
TOTAL	**$1,855,652**	**$707,976**	**$1,147,677**

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.

	FY 2013-14	FY 2014-15
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:

	FY 2013-14	FY 2014-15
Total Funds	$21,338,271	$22,005,520
General Funds	$4,211,152	$3,625,843

	FY 2013-14		FY 2014-15	
	Total Funds	GF	Total Funds	GF
Medi-Cal Fiscal Intermediary				
Code Conv/Secur/Trans (SG)	$10,943,858	$2,674,937	$5,840,100	$1,501,740
UPN Project Manager HIPAA-1 (CR)	$116,580	$29,145	$0	$0
ICD-10 HIPAA Medical Coders HIPAA-2 (CR)	$144,000	$16,992	$171,000	$20,178
Code Conversion Proj Mgr HIPAA-1 (CR)	$116,580	$29,145	$0	$0
ICD-10 Gap Analysis	$116,670	$11,667	$1,283,330	$128,333
5010 Legacy Enhancements	$4,814,200	$576,741	$0	$0
ICD-10 Enhancements	$3,302,383	$395,625	$13,209,530	$1,582,502
IV&V Contractor for HIPAA 5010 & ICD-10	$50,000	$5,900	$150,000	$17,700
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 HIPPA ICD-10	$134,400	$33,600	$0	$0
HIPAA ICD-10 PM	$138,600	$34,650	$241,560	$60,390
Code Management Tool - Tra	$147,000	$36,750	$50,000	$37,500
Total Medical FI	**$20,624,271**	**$4,032,652**	**$21,545,520**	**$3,510,843**
Dental				
HIPAA Security (CO)	$300,000	$75,000	$310,000	$77,500
Development – CDT (SG) 25%	$390,000	$97,500	$150,000	$37,500
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
Total Dental FI (Delta)	**$714,000**	**$178,500**	**$460,000**	**$115,000**
HCO				
NPI (CR)	$0	$0	$0	$0
Total HCO FI (Maximus)	$0	$0	$0	$0
Total HIPAA	**$21,338,271**	**$4,211,152**	**$22,005,520**	**$3,625,843**

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
May 2014
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	
C/Y	B/Y

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
E 1	(OA-10) (OA-69)	X		Single Point of Entry 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. 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. 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. **Consistent with the use of the new single streamlined application, beginning January 1, 2014, the Department instructed MAXIMUS to closeout SPE application services and to refer applicants to use the application portal and toll-free line at Covered CA. The shutdown process will be completed in FY 2013-14.**
E 2	(PC-12)	X	X	Resource Disregard – % Program Children 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).
E 3	(PC-11)	X	X	New Qualified Immigrants 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

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.
E 4	(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 5	(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 6	(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 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

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				(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 7	(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 8	(OA-NA)	X	X	Maternal and Child Health-CDPH This assumption has been moved to the “Other: Reimbursements” section.
E 9	(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).

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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. 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 10	(CA-4)	X	X	<u>CalWORKs Applications</u> 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 11	(PC-6) (PC-FI)	X	X	<u>CHDP Gateway</u> This assumption has been moved to the “Fully Incorporated Into Base/Data Ongoing” section. As a result of the Healthy Families’ transition to Medi-Cal these costs are now included in the Base estimate.
E 12	(OA-77)	X	X	<u>Merit System Services for Counties</u> Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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 13	(CA-NA)	X	X	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 Department of Finance, or state employee salary increases, whichever is greater.
E 14	(CA-7)	X	X	Los Angeles County Hospital Intakes 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 15	(CA-NA)			Eligible Growth 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 was not funded in FY 2013-14 and will not be funded in FY 2014-2015.

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
E 16	(OA-66)	X	X	Department of Social Services Administrative Costs 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: • In-Home Supportive Services (IHSS) programs (which include Community First Choice Option, Personal Care Services Program and the IHSS Plus Option), • Child Welfare Services/Case Management System (CWS/CMS), and the • Statewide Automated Welfare System (SAWS).
E 17	(PC-15) (PC-16) (PC-17)	X	X	Public Assistance Reporting Information System (PARIS) 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 beneficiary information with other states to identify changes in residence and public assistance benefits in other states.
E 18	(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 2013-14, the Department ~~plans to complete~~ **completed** the final reconciliation for FY 2011-12 and an interim reconciliation for FY 2012-13. In FY 2014-15, the Department plans to do a final reconciliation for FY 2012-13.
E 19	(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

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				~~is used to support~~ **supports** 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. **CMS issued new federal guidance resulting from the implementation of the Affordable Care Act. Beginning in early 2014, the Department plans to use Q5i to support new quality control pilot projects that replace MEQC and PERM. The new pilot requirements necessitate additional funds to modify Q5i.**
E 20	(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. 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~~ **includes** supporting the Advance Premium Tax Credit (APTC) and Cost Share Reduction (CSR) programs ~~after~~ **beginning** January 2014. The MEDS system will develop unique identifiers for the new population.

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
E 21	(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 22	(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 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 23	(PC-5) (PC-7) (OA-39)	X	X	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.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			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~~ **were** 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 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 24 ~~(PC-1)~~	X	X	Transition of Healthy Families Children to Medi-Cal

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

(PC-75)
(PC-FI)
(OA-10)
(CA-5)
(PC-73)

Pursuant to AB 1494 (Chapter 28, Statutes of 2012), effective January 1, 2013, children subscribed in the HFP began transitioning into Medi-Cal through a phase-in methodology. **The final group transitioned effective November 1, 2013. The FFS and managed care estimates have been fully incorporated into the base estimates.** 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.

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~~ **December** 2012, the Department began mailing written notices to beneficiaries enrolled in HFP explaining their transition to the Medi-Cal Managed Care program. The mailings ~~will continue throughout 2013~~ **continued through January 2014**. 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

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				mental health departments are eligible to claim FFP through the CPE process.
E 25	(PC-NA)	X	X	Maternal and Child Health Access (MCHA) vs. DHCS and MRMIB This assumption has been moved to the "Fully Incorporated Into Base Data/Ongoing" section.
E 26	(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 27	(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 28	(PC-4)	X	X	AIM Linked Infants 250-300% FPL Effective November 1, 2013, Access for Infants and Mothers (AIM) Linked Infants ~~will begin transitioning~~ began to **transition from the Managed Risk Medical Insurance Board (MRMIB)** into the Medi-Cal **managed care** delivery system. The transition was completed February 2014. ~~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 29	(PC-29) (CA-8)	X	**X**	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. **This program sunset on**

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				December 31, 2013 with implementation of ACA extending coverage to all former foster care youth up to age 26.
E 30	(PC-10)	~~X~~	X	County Health Initiative Matching Program 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~~ **300** 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~~ **began** transitioning into the Medi-Cal **managed care** 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 July 1, 2014, DHCS ~~will be~~ ~~**was**~~ **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 non-federal share, State General Fund shall be provided until the MOE obligation is no longer applicable.
E 31	(CA-NA)	X	X	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 2014-15.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 32 (PC-212)	~~X~~	X	AIM Linked Mothers 200-300% FPL

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

E 33 (CA-01)	X	X	**County Administration Base**

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 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. It consists of the costs identified for three sub-categories:

(1) Staff costs
(2) Staff development
(3) Support costs

The Department froze the county administration base in FY 2010-2011 through FY 2014-15. In FY 2013-14, the Department, the County Welfare Directors Association, and the counties, plan to create a work group to create a new methodology to calculate the base funding. W&I Code 14154 (6)(C)mandates the new methodology be implemented no sooner than FY 2015-16.

AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA ~~will establish~~ **establishes** 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~~ **former** practice of using various income disregards to adjust family income ~~will be~~ **was** replaced with a single 5% income disregard. The ACA ~~will also simplify~~ **simplifies** the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons ~~will~~ **did** not change.

The new standard ~~will allow~~ **allows** 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~~ **imposes** 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 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~~ **provides** 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.~~

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS Secretary-approved plan option, which allows DHCS to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows DHCS to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

AFFORDABLE CARE ACT: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
ACA 0.1 (PC-217)	X	X	ACA MAGI Savings

Effective January 1, 2014, the ACA provides states the option to expand eligibility to a new group of individuals: adults, age 19-64. For this new ACA expansion group, the ACA will provide California with enhanced FFP, starting at 100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and beyond.

AB 82 (Chapter 23, Statutes 2013) directs the Department to identify savings related to select populations who were eligible prior to the ACA, but now take-up coverage as part of the ACA expansion group. The savings is related to the difference between the standard FMAP and the new enhanced FMAP.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
ACA 1 (PC-19)	X	X	Payments to Primary Care Physicians

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. CMS approved SPA 13-003 in October 2013.

ACA 2 (PC-34)	X	X	Managed Care Drug Rebates

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:

- Geographic Managed Care (GMC) health plans
- Two-Plan model health plans, and the
- Health Plan of San Mateo (HPSM), a County Organized Health System (COHS).

Previously, only COHS health plans except for HPSM were subject to the rebate requirement.

The Department **began invoicing drug manufacturers for MCO rebates in March 2013** ~~will invoice for these rebates~~, retroactive to March 23, 2010~~, beginning in March 2013~~.

ACA 3 (OA-8)	X	X	CalHEERS Development

The ACA mandates the establishment of health insurance exchanges, in California, known as Covered California 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 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

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			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 4 (OA-8)	X	X	MEDS Interface with CalHEERS CalHEERS will be programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through Covered California **and** 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.
(OA-40)	X	X	MEDS Modernization The Department hired contractors to conduct a feasibility study and develop a federal Advance Planning Document (APD) to modernize MEDS. The Department plans to finalize and ~~send~~ **submit** ~~CMS the~~ **a Planning** APD to obtain **federal funding** approval for the MEDS modernization project **planning phase** in FY 2013-14. The Department anticipates hiring contractors to assist with: • **Project Planning,** • **Business Rules Extraction and Documentation,** • **Technical Consulting Services,** • The writing of the Request for Proposal (RFP), **and** • Procurement. • ~~Design,~~ • ~~Development, and~~ • ~~Implementation.~~

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			In addition, the Department plans to implement infrastructure components which will provide support for the MEDS modernization project. The MEDS modernization will transition MEDS from a stand-alone legacy system to a modernized, integrated solution that **effectively** addresses ~~the~~ requirements of the Affordable Care Act, and increases the Department's alignment with the federal Medicaid Information Technology Architecture (MITA). The ~~Department anticipates that the~~ MEDS Modernization ~~project~~ **project's planning phase is scheduled to** ~~will~~ start in ~~July~~ **March** 2014 and continue through June ~~2020~~ **2016**. **Subsequent phases will include design, development, and implementation activities.**
ACA 5 (OA-28)	X	X	Prevention of Chronic Disease Grant Project 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.
ACA 6 (PC-20)	X	X	Community First Choice Option 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. 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.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			On May 7, 2012, CMS released the final regulation requiring that to be eligible to receive CFC services; individuals must meet the following requirements: • An institutional level of care furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, • An institution providing psychiatric services for individuals under 21, or • An institution for mental diseases for individuals age 65 or over. Since California submitted its SPA prior to the publication of the final regulation, CMS ~~will provide~~ **provided** the State with a transitional period of one year from the effective date of the CFC**O** final regulation to comply with the eligibility criteria in the final regulation. This level of care criteria expired on July 6, 2013. Thus, the Department submitted SPA 13-007 on May 3, 2013, with an effective date of July 1, 2013, to reflect updates to the State Plan that are in compliance with the final regulation.
ACA 7 (PC-FI)	X	X	Implementation of ACA Rules 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. To work towards compliance, the Dental FI ~~needs to hire additional staff. Additional costs are expected to be incurred beginning in September 2013.~~ **hired additional staff.**
ACA 8 (PC-24) (PC-148)	X	X	Add-on for LTC (Non-AB 1629 & AB 1629) Facilities Effective 2015, 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 2015.
ACA 9 (PC-31) (OA-57)	X	X	Recovery Audit Contractor SB 1529 (Chapter 797, Statutes of 2012) authorizes the Department to enter into contracts with one or more eligible

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			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: • 12.5% of amounts recovered after an identified overpayment, and • 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 approved the final contract in FY 2012-13.
ACA 10 (PC-FI)	X	X	<u>HIPAA Operating Rules</u> 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 11 (PC-NA)	X (PC-NA)	X	<u>Disproportionate Share Hospital Reduction</u> This assumption has been moved to the "Information Only" section.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
ACA 12 (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 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~~ **procured** a contractor to provide technical support for the design, development and implementation, and ongoing operation and maintenance of the ETL data solution.
ACA 13 (PC-21) (PC-28) (OA-13)	X	X	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. **Additionally, the ACA requires the expansion of Foster Care Medicaid coverage to age 26.** The expansion population ~~will be~~ **is** 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. **Beginning January 1, 2014, the Department will postpone redeterminations for 5-months for all Medi-Cal beneficiaries. This 5-month delay assists counties with additional time in order to process the new incoming ACA expansion beneficiaries.**
ACA 14 (PC-30)	X	X	1% FMAP Increase for Preventive Services Effective January 1, 2013, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% in FMAP for

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			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. **The Department received CMS approval of the SPA on November 7, 2013.**
ACA 15 (PC-23)	X	X	ACA Expansion Adult Inmates Inpatient Hospital Costs 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.
ACA 16 (CA-3)	X	X	Implementation of ACA Effective October 1, 2013, open enrollment ~~begins~~ **began** 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~~ **provided** additional funding to counties to: • Make changes to existing county call centers; • Create new county call centers; • Hire additional staff needed to handle the expected increase in workload; and, • Train new and existing staff on the new rules and system changes.
ACA 17 (PC-18) (PC-26) (OA-13) (OA-9)	X	X	ACA Optional Expansion 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~~ **is**

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

access substance use disorder treatment services**,** ~~and/or~~ mental health services**, and Long Term Services and Supports (LTSS) benefits, if medical necessity is met. State Plan LTSS are federally required for the medically frail expansion population; CMS has denied the Department's request to employ an asset evaluation during an eligibility determination due to federal statutory MAGI requirements**.

The ACA provides California with enhanced FFP for the newly eligible adults at the following rates:

100% FFP from 2014 to 2016,
95% FFP in 2017,
94% FFP in 2018,
93% FFP in 2019,
90% FFP in 2020 and beyond.

The Department also expects a significant number of newly eligible beneficiaries who are not eligible for full scope coverage due to immigration status will receive restricted scope coverage. Non-emergency expenditures for this population are ineligible for FFP.

Effective January 1, ~~2014~~ **2015**, 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 18 (PC-210)X 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.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
ACA 19 (PC-27)	X	X	USPSTF Grade A and B Recommendations 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, **effective January 1, 2014,** the Department ~~will~~ **has** update**d** its coverage and **added** billing codes to comply with recommendations made by the USPSTF.
ACA 20 (PC-25) (~~OA-26~~) **(PC-FI)**	X	X	ACA Hospital Presumptive Eligibility The ACA requires the Department to give hospitals the option, as of January 1, 2014, to determine presumptive eligibility **(PE)** for Medicaid. A qualified hospital may elect to make ~~presumptive eligibility~~ **PE** determinations on the basis of preliminary information and according to policies and procedures established by the Department. **The PE period is up to 60 days. If an individual submits an application for ongoing coverage before the 60 day period ends, PE will continue until a final eligibility determination is made.** The Department will permit ~~presumptive eligibility~~ **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 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.~~ **Participating hospitals use an abbreviated application process and online portal similar to the CHDP Gateway program.**

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
ACA 21 (PC 205) (Reworded)	X	X	Health Insurer Fee Effective January 1, 2014, the ACA imposes a fee on health insurers based on their Medicare, Medicaid, SCHIP, and commercial revenue, with some exceptions. Managed care rate increases will be necessary to account for the fee Medi-Cal managed care plans will be assessed on their Medi-Cal revenue.
ACA 22 (PC 206) **(PC-FI)**	X	X	ACA Express Lane Enrollment The Centers for Medicare and Medicaid Services (CMS) 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:~~ **In December 2013, CMS approved the Department's waiver to provide Express Lane Enrollment into Medi-Cal for the following groups:** • CalFresh adult and children eligibles; and • Parents/caretaker relatives of Medi-Cal income eligible children. **On February 2, 2014, the Department began mailing special informing notices to over 600,000 CalFresh eligible adults and children in County Organized Health Care System (COHS) and non-COHS managed care counties.**
ACA 23 (CA-14)	X	X	Enhanced Federal Funding 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.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
ACA 24	**(OA-9)**	**X**	**X**	**ACA Outreach and Enrollment Counselors**

AB 82 (Chapter 23, Statutes of 2013), Section 71 authorizes the Department of Health Care Services (DHCS) to receive private funds from the California Endowment (TCE) in the amount of $14,000,000 for Certified Enrollment Counselors and Certified Insurance Agents to receive enrollment assistance payments in the amount of fifty-eight dollars ($58) for each approved Medi-Cal application if the Medi-Cal applicant(s) is newly eligible (pursuant to ACA) or was not enrolled in Medi-Cal for 12 months or more (prior to the application date). Payments will be issued by Covered California.

AB 82, Section 70 authorizes DHCS to receive private funds from the California Endowment (TCE) in the amount of $12,500,000 and will seek an equal amount in federal matching funds for purposes of implementing the Outreach and Enrollment grant funding to counties to supplement, but not supplant, Medi-Cal O&E efforts associated with the implementation of ACA. Medi-Cal O&E grant efforts must place special emphasis on one or more of the following populations:

- **Persons with mental health disorder needs;**
- **Persons with substance use disorder needs;**
- **Persons who are homeless;**
- **Young men of color;**
- **Persons who are in county jail, state, prison, on state parole, on county probation, or under post release community supervision;**
- **Families of mixed-immigration status;**
- **Persons with limited English proficiency**

BENEFITS: NEW ASSUMPTIONS

	Applicable C/Y	F/Y B/Y	
B. 01 (PC-219)		X	Vision Outreach

The Department will implement a three-year pilot program in Los Angeles County to increase utilization of vision services and eye glasses to children at school sites. The managed care plans in the Los Angeles County will contract directly with a mobile vision provider for the provision of these services. Capitation rate adjustments for the two managed care plans in Los Angeles County will be actuarially based and developed using projections of contingent events, including targeted populations who will receive these services to account for the increased utilization.

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~~ **county Child Health and Disability Prevention (CHDP) programs** 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~~ **Public Safety** Realignment Initiative (Realignment) ~~shifted the~~ **provides for a shift of** responsibilities for ~~California child welfare system to the counties~~ **the Health Care Program for Children in Foster Care (HCPCFC) to local control under county welfare departments**. Vehicle License Fund and Sales Tax revenues, ~~supplant the GF as the non-federal share~~ **which fund the state share of the program, will be transferred to the counties**. ~~Due to concerns from state, federal, and local stakeholders that Realignment would effectively eliminate this program as a cohesive and effective statewide system~~ **To enable this transition**, SB 1013 (Chapter 35, Statutes of 2012) provides continuing funding ~~under the existing model to~~ **for the existing HCPCFC model for** local ~~Child Health and Disability Prevention~~ **CHDP** programs **to staff the HCPCFC with CHDP nursing staff through June 30, 2015**. 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 continues to work on a timeline that will transfer the Health Care Program for Children in Foster Care to local control.~~ **CDSS is developing a timeline that will result in the transition of the HCPCFC to full local control under the county welfare departments, effective July 1, 2015.**

BENEFITS: OLD ASSUMPTIONS

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-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) (OA-7) X X 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

BENEFITS: OLD ASSUMPTIONS

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 additional funds, such as special local initiatives and Proposition 10 fund spending determination of LGA status, are made available as the certified public expenditure.

In June 2012, CMS deferred the school-based MAA Program retroactively to October 2011 and will release deferred invoices on a flow basis as certain criteria are met and a new SMAA manual is implemented. The Department developed the new invoice criteria and anticipates that invoices will be paid beginning in the last quarter of FY 2013-14 and a new SMAA manual will be implemented July 1, 2014.

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.

BENEFITS: OLD ASSUMPTIONS

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;
- CCMP-SMI (CCM-2): Persons with chronic health condition(s) and serious mental illnesses. The SMI portion 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 expired on July 31, 2013.

B 8 (PC-194) X X CLPP Funding for EPSDT Lead Screens

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.

B 9 (PC-NA) X X Hearing Aid Cap

This assumption has been moved to the “Fully Incorporated into Base Data/Ongoing” section

B 10 (PC-50) ~~X~~ X Copayment for Non-Emergency ER Visits

AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of up to $50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented 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

BENEFITS: OLD ASSUMPTIONS

copayments, an emergency service is defined as the treatment of an emergency medical condition or services that result in an inpatient admission.

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~~ **July** 2014.

B 11 (PC-182) X X EPSDT Screens

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.

B 12 (PC-184) (OA-72) X X CDDS Dental Services

The Lanterman Act requires the California Department of Development Services (CDDS) to provide dental services to its clients. Because Medi-Cal no longer covers many 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. 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. Processing of CDDS claims started on January 12, 2012.

B 13 (OA-74) X X Quitline Administrative Services

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.

BENEFITS: OLD ASSUMPTIONS

B 14 (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 15 (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.

B 16 (OA-32) (OA-78) X X Family PACT Support, Provider Education and Client Outreach

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

BENEFITS: OLD ASSUMPTIONS

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.

B 17 (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.

B 18 (PC-FI) X X Family PACT Systems

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.

B 19 (OA-12) X X Family PACT HIPAA Privacy Practices Beneficiary Notification

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.

B 20 (PC-NA) X X Increased Federal Matching Funds for FPACT

This assumption has been moved to “Fully Incorporated into Base Data/Ongoing.”

B 21 (PC-42) X X Dense Breast Notification Supplemental Screening

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

BENEFITS: OLD ASSUMPTIONS

(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.

B 22 (PC-40) X X <u>California Children's Services Program Pilots</u>

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. 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 began operations effective April 1, 2013

B 23 (PC-38) (OA-24) X X <u>Restoration of Select Adult Dental Benefits</u>

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, prophylaxsis, 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.

B 24 (OA-59) ~~X~~ X <u>Newborn Hearing Screening Program</u>

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

BENEFITS: OLD ASSUMPTIONS

Assistance Appropriations and the contract services are budgeted in the State Support Appropriations.

The NHSP inpatient and outpatient hearing screens, the diagnostic hearing evaluations, and medical interventions are budgeted in the Medi-Cal and Family Health Estimates.

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 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.

B 25 (PC-51) X X ~~Change Family PACT Program Benefits~~ **Women's Health Services**

The ~~Office of Family Planning~~ **Department** conducts on-going monitoring and utilization management of ~~the Family PACT program~~ **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. Effective November 1, 2013, the Department plans to:

- Decrease ~~over-utilization~~ **the onsite dispensing** of emergency contraception **under Family PACT from two packs to one pack per dispensing**,
- Add clinic dispensing of the emergency contraceptive, ella®,
- Eliminate urine culture, ~~and~~
- Discontinue brand name anti-fungal drugs,
- **Increase the dispensing fee for Long-Acting Reversible Contraceptives (LARCs), and**
- **Increase reimbursement rates for pregnancy termination services under Medi-Cal by 40%.**

BENEFITS: OLD ASSUMPTIONS

Effective January 1, 2014, the Department plans to:

- 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 26 (PC-66) X X <u>Voluntary Inpatient Detoxification</u>

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 27 (PC-208) X X <u>Children's Dental Utilization</u>

Centers for Medicare and Medicaid Services (CMS) has 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.

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 supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select 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~~ **services and supports**, care coordination, community transition, ~~translation/interpretation,~~ and home modification in ten counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, 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 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.~~**; a proposal to renew the waiver for an additional five years was submitted to CMS on November 27, 2013, with an anticipated effective date of March 1, 2014.**

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**; the CBAS portion ends on August 31, 2014**. 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. As of October 1, 2012, CBAS was transitioned into all managed care health plans. There is no cap on enrollment into this waiver service. **The Department is seeking to amend the BTR 1115 waiver extending CBAS through the life of the waiver.**

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. **The Department will submit a renewal to CMS requesting an extension of the waiver from January 1, 2015 through December 31, 2019.**

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 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) 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:

- 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.

HOME AND COMMUNITY BASED SERVICES

- 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.
- 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.

The SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, **CMS approved** a waiver amendment ~~has been submitted to adjust~~ **on September 23, 2013 which adjusted** 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:

- **Administrative Expenses;**
- Attendant care;
- Case management;
- Financial supplements for foster care;
- Home-delivered meals;
- **Homemaker services;**
- **In-home** skilled nursing **care**;
- Minor physical adaptations to the home;
- Non-emergency medical transportation;
- Nutritional counseling;
- Nutritional supplements;
- Psychotherapy;
- **Specialized** medical equipment and supplies.

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

HOME AND COMMUNITY BASED SERVICES

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, **and 4,570 in 2015**. 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 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 13,080 for 2013 and 2014. The waiver is approved from July 1, 2009 through June 30, 2014. **Pursuant to the Coordinated Care Initiative, the Department will submit an amendment to CMS requesting the inclusion of MSSP as a managed care component; the Department will also request the renewal of the waiver from July 1, 2014 through June 30, 2019.**

Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)

The DD Waiver provides home and community-based services to ~~developmentally disabled~~ persons **with developmental disabilities** 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 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 effective April 1, 2012 through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800.

HOME AND COMMUNITY BASED SERVICES

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 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	
H 0.1 (PC-216)		X	Homemaker Services – AIDS Medi-Cal Waiver

Rates for homemaker services must be increased to meet the higher State minimum wage requirements beginning July 1, 2014.

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~~ **help** persons ~~needing~~ **who prefer to receive** long-term ~~care supported and safe~~ **services and supports** 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 CDSS' 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); **and** an eight-year federal demonstration to transition LTC 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) (OA-70)	X	X	B. Multipurpose Senior Services Program – CDA
			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, 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 otherwise require care in a nursing facility.

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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 April 1, 2014~~ **As CCI is implemented**, 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) (OA-61)	X	X	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 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) (PC-43) (PC-52) (OA-44)	X	X	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 and 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	Health-Related Activities - CDSS

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.

H 7	(OA-70)	X	X	Department of Aging – Administrative Costs

The federal government provides Title XIX federal financial participation to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services and the Multipurpose Senior Services Program.

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).

H 8	(PC-122)	X	X	PACE: Program of All-Inclusive Care for the Elderly

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.

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). 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 in alignment with the Department's goal for standardization of managed care rate methodologies. PACE rates are set on a calendar year basis, to coincide with the time period of the contracts. The anticipated effective date of the new rate methodology will be in FY 2015-16.

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
H 9	(PC-126) (PC-141)	X	X	Senior Care Action Network

The Senior Care Action Network (SCAN) is a Medicare Advantage Special Needs Plan located in Long Beach that 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 had a five-year contract with the Department that ended on December 31, 2012, but was extended for two additional years through December 31, 2014. 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.

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. Rates through 2013 are developed based on the plans' actual experience. To determine 2014 rates, SCAN ~~will submit~~ **submitted** 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. AB 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	Pediatric Palliative Care Waiver

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

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				evaluate the pilot project. An independent evaluation of the waiver is also required to meet federal assurances. Effective July 2013, the participating agencies will receive reimbursement for administrative costs.
H 11	(PC-45)	X	X	<u>SF Community-Living Support Benefit Waiver</u> 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. 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. 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.
H 12	(PC-35)	X	X	<u>Additional HCBS for Regional Center Clients</u> 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. The SPA was approved April 25, 2013, retroactive

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				to October 1, 2009. 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~~ **was submitted to CMS on November 21, 2013 proposing** 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. A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011. **The Department is no longer seeking to amend the 1915(i) SPA to add infant development services. Under CMS guidance, the Department is currently seeking to amend an existing interagency agreement with the California Department of Developmental Services to draw down FFP for infant development services.** ~~Per CMS guidance, this SPA will be modified to add infant development services as an EPSDT benefit.~~ 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.
H 13	(OA-44)	X	X	CCT Enrollment – Expanded Outreach Administrative Costs 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.
H 14	(PC-46)	X	X	Quality of Life (QoL) Surveys for Community Care Transitions (CCT) Participants 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 survey methodology. CCT/MFP has participation agreements with lead organizations, which are Medi-Cal home and community-

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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.
H 15	(OA-20)	X		ADHC Transition
	(reworded)			AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program in FY 2011-12. 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. Associated transition costs have been incurred by the Department for: • Enhanced Case Management, • Fair Hearing outcomes and penalties, and • Administrative law judges
H 16	(PC-201)			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 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. **The Department is currently working with CMS and key stakeholders on development of this assessment in accordance with the settlement.**

BREAST AND CERVICAL CANCER TREATMENT: NEW ASSUMPTIONS

Applicable C/Y	F/Y B/Y

BREAST AND CERVICAL CANCER TREARMENT: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
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. DHCS 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 TREARMENT: 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

PHARMACY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
PH 1	(PC-54)	X	X	Non FFP Drugs

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.

PH 2	(PC-57)	X	X	Family PACT Drug Rebates

The Department collects rebates for family planning drugs covered through the Family PACT program.

PH 3	(PC-60)	X	X	State Supplemental Drug Rebates

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.

PH 4	(PC-61)	X	X	Federal Drug Rebate Program

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 percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.

PHARMACY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
PH 5	(PC-56)	X	X	Medical Supply Rebates

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.

The product reimbursement rates for diabetic test strips and lancets are based on the contracted MAC.

On January 1, 2013, newly negotiated three-year contract terms went into effect and reduced the Department's net cost per claim.

PH 6	(PC-59)	X	X	Aged and Disputed Drug Rebates

The Department collects drug rebates as required by federal and state laws. The Department has completed its work on the oldest aged rebate disputes and is working on disputes for more recent periods.

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.

The rebates under this category will be higher over the next two years because the rebates associated with Managed Care Organizations (MCOs) are included. As retroactive billings are completed, the MCO disputes will decline and will be more consistent in the future.

PH 7	(OA-51)	X	X	Epocrates

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.

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
PH 8 (PC-55)	X	X	BCCTP Drug Rebates

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.

PH 9 (OA-60)	X	X	Rate Studies for MAIC and AAC Vendor

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 must hire a contractor. 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.~~

The procurement **for a contractor to establish the MAICs** is anticipated to occur in FY 2014-15 following ~~the~~ settlement of **the pending** litigation ~~and approval of the State Plan Amendment~~.

PH 10 (PC-53)	X	X	Restoration of Enteral Nutrition Benefit

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.

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
PH 11 (PC-211)	X	X	MCO Supplemental Drug Rebate

For Managed Care Organization (MCO) drug rebates, 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.

DRUG MEDI-CAL: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
D 1	(PC-63)	X	X	Residential Treatment Services

The Residential Treatment Services program provides rehabilitation services to beneficiaries with substance use disorder diagnoses in a non-institutional, non-medical, residential setting. Each beneficiary resides on the premises and receives support in 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.

~~Beginning January 1, 2014, as a result of California's adoption of the ACA,~~ **The Department submitted a SPA, effective January 1, 2014, to remove** the previous limitation ~~to~~ **from** only pregnant, postpartum or EPSDT eligible beneficiaries ~~will be removed and~~ **to** all Medi-Cal beneficiaries who meet the service criteria ~~may receive the service~~.

D 2	(PC-65)	X	X	Intensive Outpatient **Treatment** Services

Intensive Outpatient **Treatment** services provide outpatient counseling and rehabilitation services at least three hours per day, three days per week to persons with substance use disorder diagnoses.

~~Beginning January 1, 2014, as a result of California's adoption of the ACA,~~ **The Department submitted a SPA, effective January 1, 2014, to remove** the previous limitation ~~to~~ **from** only pregnant, postpartum or EPSDT eligible beneficiaries ~~will be removed and~~ **to** all Medi-Cal beneficiaries who meet the service criteria ~~may receive the service~~.

D 3	(PC-64)	X	X	Outpatient Drug Free Treatment Services

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 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.

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
D 4	(PC-62)	X	X	Narcotic Treatment Program

The Narcotic Treatment Program 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.

D 5	(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 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.

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
D 6	(PC-68)	~~X~~	X	Annual Rate Adjustment

The Department annually adjusts the Drug Medi-Cal rates~~. For~~ **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.

D 7	(OA-58)		X	Drug Medi-Cal County Administration

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.

D 8	(OA-80)	X	X	Third Party Validation of Certified Providers

The Department ~~will procure a~~ **was able to utilize** 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.

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

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				Death Records; (d) State Licensure Sanctions; and (e) National Provider Identification (NPI) Deactivations.
D 9	(PC-203)	X	X	Provider Fraud Impact to DMC Program 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 **2013**. As of ~~August, 30, 2013~~ **March 18, 2014**, the Department has issued temporary suspensions for ~~139~~ **235** providers and 117 Good Cause Exceptions out of the 1,063 certified DMC providers and lodged ~~51~~ **89** Credible Allegations of Fraud with the California Department of Justice for potential prosecution.

MENTAL HEALTH: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 1(PC-69) (PC-70)	X	X	Specialty Mental Health Services

The Medi-Cal Specialty Mental Health Services waiver program provides inpatient, targeted case management, and rehabilitative mental health services to adults and children enrolled in the Medi-Cal program and meet the medical necessity criteria.

Adult: The mental health plan authorizes the delivery of specialty mental health services in accordance with state regulations and contract requirements for services provided to adults.

Children: The mental health plan authorizes the delivery of specialty mental health services in accordance with state regulations and contract requirements for services 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.

The Department contracts with ~~a~~ mental health plans, to provide or arrange and pay for the provision of specialty mental health services to all individuals enrolled in the Medi-Cal program that meet the medical necessity criteria for specialty mental health services.

MH 2 (PC-75)	X	X	Healthy Families Program SED

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, and
- Income is at or below 250 percent of the federal poverty level.

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

MENTAL HEALTH: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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. Beginning January 1, 2013, the HFP ceased to enroll new subscribers and the current HFP subscribers were phased into the Medi-Cal program.
MH 3	(PC-80) ~~(PC-82)~~	X	X	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 negotiated a plan for the county to reimburse the State for the repayment.
MH 5	(PC-83) (OA-5)	X	X	Interim and Final Cost Settlements–Specialty Mental Health Services Within two years following the end of a fiscal year, the Department reconciles interim payments to MHPs for children and adults specialty mental health services via interim cost report settlements. The Department processes correcting payments or recoupments depending on each county's interim cost report settlement amount. Subsequent to the interim settlement, the Department conducts a final cost settlement audit resulting in a final audit payment or recoupment.

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 6 (PC-81)	X	X	Chart Review

The Department conducts on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries. 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.

MH 7 (PC-78)	X	~~X~~	Solano County SMHS Realignment Carve-Out

Prior to FY 2012-13, the Medi-Cal managed care program "carved in" specialty mental health services for Solano County.

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.

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.

MH 8 (PC-77)	X	X	Over One-Year Claims

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.

MH 9 (OA-3)	X	X	County Specialty Mental Health Administration

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.

MH 10 (OA-14)	X	X	County Utilization Review and Quality Assurance

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.

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 11 (OA-55) (PC-74)	X	X	*Katie A. v. Diana Bontá* – Special Master 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 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. 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 12 (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.

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			The current contract ends in June 2014. ~~The FY 2012-13 budget was included in support, but beginning with FY 2013-14 it is part of the local assistance estimate.~~ **The Department is in the process of extending the contract**. ~~In addition, the Department is requesting funding for a~~ **The** PASRR information technology (IT) project **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. The IT project will replace an inefficient mainframe ~~database~~ **system** with ~~a database~~ **one** 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% FF and 25% GF.
MH 13(PC-72)	X	X	Elimination of State Maximum Rates Assembly Bill 1297 (Chapter 651, Statues of 2011) eliminated the state maximum rates paid for Medi-Cal specialty mental health 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 14(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.

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 15(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 16(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.

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~~ **beginning May 2014**.

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 C/Y	B/Y	
W 1	(PC-88) (PC-104)	X	X	MH/UCD & BTR—Safety Net Care Pool

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).
- 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
  - 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~~ **undocumented individuals** 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% of uncompensated care costs. (~~Two~~ **Three** University of California hospitals**, UCSF Medical Center and two UCLA Medical Centers,** 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. • 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	<u>MH/UCD & BTR—Private Hospital DSH Replacement</u> 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	MH/UCD & BTR—Private Hospital Supplemental Payment 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.
W 5	(PC-103)	X	X	MH/UCD & BTR—NDPH Supplemental Payment 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.
W 6	(PC-94)	X	X	MH/UCD & BTR—DPH Physician and Non-Physician Costs 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

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-105)	X	X	MH/UCD& BTR—MIA LTC Program– Safety Net Care Pool 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 8	(PC-106)	X	X	MH/UCD & BTR—BCCTP – Safety Net Care Pool 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 9	(PC-91)	X	X	MH/UCD & BTR—CCS AND GHPP – Safety Net Care Pool 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 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

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.
W 10 (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 11 (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. • 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.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			• 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. • 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~~ **began** in FY 2013-14.
W 12 (PC-102)	X	**X**	MH/UCD—Health Care Coverage Initiative An amount of $180 million in federal funds was 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 were selected to participate in the CI program. The federal funds available reimbursed 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 submitted their CPEs to the Department for verification and the Department submitted the claim for FFP that reimbursed the CI counties. No GF was expended for this program. In FY 2008-09, the Department reimbursed 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 became part of the Low Income Health Program; see the Low Income Health Program assumption.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
W 13 (PC-107)	X	X	MH/UCD & BTR—DPH Interim Rate

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.

W 14 (PC-97)	~~X~~	X	MH/UCD & BTR—DPH Interim Rate Growth

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.

W 15 (OA-37)	X	X	MMA –DSH Annual Independent Audit

MMA requires an annual independent certified audit that primarily certifies:

- 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.
- 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.

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.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
W 16	(PC-85) (PC-87)	X	**X**	MH/UCD & BTR—ARRA – DSH Allotment and DSH Replacement Payments

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.

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 2013-14 **and FY 2014-15**.

W 17	(PC-110)	X	**X**	MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool

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 began in FY 2012-13.

W 18	(PC-86) (PC-92)	X	X	BTR—Delivery System Reform Incentive Pool

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 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
5. HIV Transition Projects

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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. Incentive funding for these projects will be effective from July 1, 2012 through October 31, 2015. Intergovernmental transfers (IGTs) are used as the non-federal share to claim the federal funding for DSRIP.
W 19	(PC-84) (PC-90)	X	**X**	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 consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). These were county-based elective programs that ended on December 31, 2013 when these individuals became eligible for Medi-Cal or Covered California, as appropriate under the Affordable Care Act. The counties used the following methodologies to obtain federal funding: • CPEs • IGTs for capitation rates payments • IGTs for county-owned FQHCs (CMS approved this claiming protocol on February 5, 2013) Counties that participated in the HCCI under the MH/UCD and elected not to participate in the HCCI component of the LIHP continued to provide health care services for existing enrollees and received federal funding for these services.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			a. MCE covered individuals who had family incomes at or below 133% FPL. The MCE program was not subject to a federal funding cap. b. HCCI covered individuals who had family incomes above 133% through 200% of FPL. Federal funding for HCCI was subject to a cap of $180 million for the first three demonstration years and $90 million for the last year ending December 31, 2013. These caps vary annually; see the BTR-Health Care Coverage Initiative Rollover Funds assumption.

W 20 (PC-95)	X	X	<u>BTR—SNCP Designated State Health Programs</u>
			
			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
			  o California Children's Services (CCS)*
			  o Genetically Handicapped Persons Program (GHPP)*
			  o Medically Indigent Adult Long Term Care (MIA-LTC)*
			  o Breast & Cervical Cancer Treatment Program (BCCTP)*
			  o AIDS Drug Assistance Program (ADAP)
			  o Expanded Access to Primary Care (EAPC)
			  o County Mental Health Services Program
			  o Department of Developmental Services (DDS)
			  o Every Woman Counts (EWC)
			  o Prostate Cancer Treatment Program (PCTP)
			  o County Medical Services Program (CMSP); effective November 1, 2010 to December 31, 2011.
			• Workforce Development Programs
			  o 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

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	Applicable F/Y C/Y	B/Y	
			o University of California o California State University o California Community Colleges • ~~Miscellaneous programs.~~ **Reserved SNCP funds for Designated State Health Programs (DSHP).** *Separate assumptions address the federal funds for these programs.
W 21 (OA-4) (PC-FI)	X	X	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~~ **2014** 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. **The Department received CMS approval for the administrative cost claiming protocol on December 12, 2013.** Most LIHP individual transitioned into Medi-Cal managed care **or Covered California** on January 1, 2014. The Department developed notices informing beneficiaries of the transition process. Beginning November 1, 2013, approximately 600,000 notices were mailed to beneficiaries. Due to the special mailing, there will be associated costs to the State beginning in FY 2013-14 **for the Health Care Options enrollment broker to mail the special notices and to provide telephone call center customer service to LIHP beneficiaries enrolling into Medi-Cal managed care**.
W 22 (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 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

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		Applicable F/Y C/Y	B/Y	
				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 23	(PC-89) (PC-103)	X	~~X~~	Hospital Stabilization AB 1467 (Chapter 23, Statutes of 2012) provided the authority to redirect private and NDPH stabilization funding that 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 was used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 through FY 2006-07.
W 24	(PC-98) (PC-108) (PC-112)	X	X	BTR-Health Care Coverage Initiative Rollover Funds HCCI, one component of BTR, ~~covers~~ **covered** individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI ~~is~~ **was** subject to an annual cap. The Department received federal approval to reallocate the unspent DY 6, 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 25	(PC-113) (PC-FI)	X	X	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 replaces the previous payment methods. For contract hospitals, DRGs replace the per diem rates negotiated under the Selective Provider Contracting Program (SPCP). For non-contract hospitals, DRGs replace the previous cost-based reimbursement methodology. The DRG 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), implemented California Medicaid Management

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	Applicable F/Y C/Y	B/Y	
			Information Systems (CA-MMIS) changes to comply with this legislation.
W 26 (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~~ **were** not enrolled in a Low Income Health Program (LIHP).

The demonstration 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 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 are also 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 is 100% FFP. For services provided to non-IHS eligible individuals, reimbursement is claimed through certified public expenditures. There will be no GF impact.

On December 24, 2013, CMS approved an amendment to extend IHS payments effective January 1, 2014 through December 31, 2014. Eligible services for this time period are uncompensated services provided to Medi-Cal beneficiaries who are IHS eligible. Included in this amendment is a requirement to evaluate the impact of the IHS payments made under the BTR waiver. There will be no additional cost to the state as a result of this evaluation.

W 27 (PC-89)	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

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Applicable F/Y		
C/Y	B/Y	
		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. The basis for the county specific rate is the aggregate of the plan specific rates developed and

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each plan's enrollment for a weighted average county rate. For the 2013-14 rates, 40% of this county specific rate was taken and multiplied by each plan's respective risk score and 60% of each plan's plan specific rate was retained and added to the 40% risk adjusted rate to establish a risk adjusted plan specific rate. 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.

2013-14 and 2014-15 Rates

Overall, the rates represent a 3.63% increase in FY 2013-14 over the previous fiscal year rates (based on a fiscal year comparison). Rates for 2014-15 represent a 3.5% increase over the 2013-14 fiscal year rates.

MANAGED CARE: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
M 1	(PC-114)	X	X	Two-Plan Model

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.

Capitation rates include the annual rate redeterminations.

M 2	(PC-115) (PC-142)	X	X	County Organized Health Systems

Six County Organized Health Systems (COHSs) are operational in fourteen counties. 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~~ **has incorporated the** 1115 waiver requirements related to Seniors and Persons with Disabilities **into the COHS contracts**. **The eight counties that began operating in the COHS system during FY 2013-14 are accounted for in the Managed Care Expansion to Rural Counties assumption.**

Capitation rates include the annual rate redeterminations.

M 3	(PC-116)	X	X	Geographic Managed Care

Under the Geographic Managed Care model, ~~counties contract~~ **the Department contracts** with multiple ~~commercial~~ plans to provide services to beneficiaries. Currently, Sacramento and San Diego counties utilize the geographic managed care model.

Capitation rates include the annual rate redeterminations.

M 4	(PC-129)	X	X	AIDS Healthcare Centers

Managed Care Organization (MCO): Positive Healthcare Services (dba AIDS Healthcare Centers) is located in Los Angeles.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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 drugs which do not fit into one of the current therapeutic classes and for which there is not sufficient utilization data to determine the financial impact of the use of those drugs will have on the managed care plan. 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.
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. **The Department intends to extend the contract through June 30, 2015.**
M 6	(PC-118)	X	X	Managed Care Rate Range Intergovernmental Transfers ~~Counties~~ **Governmental entities** 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

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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.
M 7	(PC-135)	X	X	Managed Care IGT Administrative and Processing Fee ~~Counties~~ **Governmental entities** may 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 are used for the nonfederal share of capitation rate increases. Beginning 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~~ **governmental entities** an administrative and processing fee for their IGTs. The fee will be 20% of each IGT **contribution** and will ~~offset the cost of medical services provided under the Medi-Cal program~~ **reimburse the Department for the administrative costs of operating the IGT program. This fee is in addition to the rate range IGT and does not affect the available rate range**. 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.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
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 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.

M 10	(PC-128) (PC-133) (PC-121) (PC-137) (PC-134)	X	X	Extend Gross Premium Tax – Increase Capitation Rates

ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through FY 2011-12.

SB 78 (Chapter 33, Statutes of 2013) extended 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:

- Two Plan Model
- County Organization Health Systems
- Geographic Managed Care
- AIDS Healthcare Centers
- SCAN

M 11	(PC-138)	X	X	FFS Costs for Managed Care Enrollees

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

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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.
M 12	(OA-36)	X	X	San Diego County Administrative Activities 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.
M 13	(PC-123) (PC-143) (PC-197) (PC-119) (OA-17) (PC-FI)	X	X	Coordinated Care Initiative (CCI) 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. Enrollment notices and managed care guidebooks will be mailed to beneficiaries. Additional administrative costs will be required ~~when enrolling beneficiaries into managed care health plans~~ **due to this change**.
M 14	(PC-127) (PC-114) **(PC-215)** (PC-FI)	X	X	Managed Care Expansion to Rural Counties ~~Managed care is currently in 30 counties.~~ AB 1467 (Chapter 23, Statutes of 2012) ~~expands~~ **expanded** managed care **from 30 counties** 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 transition to managed care in the 28 counties ~~will phase in beginning~~ **began on** 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.~~ **Beneficiaries**

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				were transitioned into County Organized Health Systems or a Regional Model, including San Benito and Imperial Counties. **Current fee-for-service Seniors and Persons with Disabilities (SPDs) in rural expansion counties have the option to enroll in managed care during the transition. During FY 2014-15 SPDs are expected to transition to managed care.**
M 15	(PC-117) (PC-139) (PC-140) (PC-18) (PC-21)	X	X	MCO Tax on Managed Care Plans SB 78 (Chapter 33, Statutes of 2013) imposed ~~the~~ **a** statewide ~~sales~~ tax on Medi-Cal managed care plans effective July 1, 2013. One half of the proceeds of the tax will be used to increase rates to the plans to reimburse them for the cost of the tax. The other half of the proceeds will be used to offset General Fund cost in the Medi-Cal program.
M 16	(PC-124)	X	~~X~~	Retroactive Managed Care Rate Adjustments for FY 2012-13 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. **It is anticipated the retroactive Two-Plan model and GMC SPD rates will be paid during FY 2013-14. The retroactive rate changes for SPDs impact rate periods from July 2011 through September 2013 for Two-Plan model plans and July 2011 through December 2013 for GMC plans.**
M 17	(PC-132)		X	Annual Redetermination of Capitation Rates 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.~~

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 18 (PC-22)	X	X	Mental Health Services Expansion

SBX1 1 (Chapter 4, Statutes of 2013) provides that Medi-Cal managed care plans 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.

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.

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 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 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th 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	
PR 0.1	(PC-214)		X	Genetic Disease Screening Program Fee Increase

CDPH administers California's Genetic Disease Screening Program (GDSP) which includes the Prenatal Screening (PNS) Program and the Newborn Screening (NBS) Program. GDSP screens for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling, confirmatory testing, including ultrasound and diagnostic procedures.

Effective July 1, 2014, GDSP will implement a $45 fee increase for the PNS Program

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
PR 1			NF-B Rate Changes and Quality Assurance (QA) Fee
			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, 2015.
(PC-145) (PC-24)	X	X	AB 1629 Rate Adjustments due to QA Fee
			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.
			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%.
			QA fee 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. L&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 adjustments.
			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.

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
(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. AB 1489 (Chapter 631, Statutes of 2012) requires payments to be made by April 30, 2014.

Supplemental payments will be paid through the Skilled Nursing Facility Quality and Accountability Special Fund. The 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.

(PC-24)	X	X	AB 1629 Add-Ons

The following are the add-on rates to AB 1629 facilities:

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.

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.

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 the 2013-14 rate year.

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 the 2013-14 rate year.

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			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.
			AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage, after July 1, 2014, to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10 per hour. The current minimum wage is $8.00 per hour. An add-on for the additional costs will be effective for the 2014-15 rate year.
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 received CMS approval on ~~August 29, 2013~~ **August 28, 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 20, 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 30, 2012~~ **January 30, 2014**, the Department ~~submitted a SPA requesting~~ **received** 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~~ **received** CMS approval **on December 20,** 2013 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~~ **stopped** the 10% payment reduction in December 2013 and anticipates refunding the payment reduction for the period June 1, 2011 through November 30, 2013 by September 2014.

Effective July 1, 2014, Community-Based Adult Services providers located in San Francisco will be exempt from the 10% payment reduction.

PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				Managed care reductions pursuant to AB 97 will be implemented prospectively effective October 1, 2013. Due to 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	Annual MEI Increase for FQHCs and RHCs 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.
PR 4				LTC Rate Adjustments and QA Fees
	(PC-148)	X	X	Rate Adjustment Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of an annual rate study. The following facilities are included in this assumption: • Intermediate Care Facilities/Developmentally Disabled (ICF-DD) • ICF/DD-Habilitative • ICF/DD-Nursing • Freestanding Nursing Facilities – Level A (NF-A) • Distinct Part Nursing Facilities (DP/NF) – Level B • DP/NF Subacute • Pediatric Subacute Care • Rural Swing Beds

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
- Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing
- FS pediatric subacute facilities

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			The Department ~~will submit a SPA to CMS~~ **received CMS approval on December 20, 2013** 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.
(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.

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
- Hospice Room and Board Providers
- Rural Swing Bed Rate

The following long-term care providers are subject to the 10% payment reduction:

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y		
C/Y	B/Y	
		• 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 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~~ **implement the new rate** methodology ~~for the rate-year commencing August 1, 2013~~ **June 2014, on a prospective basis only.** The Department ~~will submit a request to CMS~~ **received CMS approval on December 20,** 2013 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. 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.
(PC-148) X	X	Non-AB 1629 Add-Ons to the Rates 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

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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.

- 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 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.

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			• 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 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.
			• **AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage, after July 1, 2014, to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10 per hour. The current minimum wage is $8.00 per hour. An add-on for the additional costs will be effective for the 2014-15 rate year.**
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.

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
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 change each year by the same percentage as the average change in Diagnosis Related Groups base prices, if there is a change.
PR 7 (PC-156)		X	Reduction to Radiology Rates 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 ~~December 2013~~ **July 2014** with rate reductions retroactive to July 1, 2012 in order to protect beneficiary access to needed radiology services.
PR 8 (PC-147)	X	X	~~Air Ambulance Medical Transportation~~ **Emergency Air Medical Transportation Act** AB 2173 (Chapter 547, Statutes of 2010) imposed an additional penalty of $4 upon every conviction involving a vehicle violation, effective January 1, 2011. The bill required 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 (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. 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.

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			The Department submitted two SPAs to CMS: • 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. • 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.
PR 9 (PC-154)		X	Laboratory Rate Methodology Change 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. 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~~ **November** 1, 2014. The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.
PR 10 (PC-151)	X	X	Long Term Care Quality Assurance Fund Expenditures 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. • Freestanding Nursing Facilities Level-B (FS/NF-Bs)

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- 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 (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 C/Y	B/Y	
SP 1	(PC-165)	X	X	Capital Project Debt Reimbursement

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&I Code.

The SPCP contracts ended on June 30, 2013, due to the implementation of the DRG payment methodology. A SPA ~~is being drafted to obtain authority~~ **was approved on December 11, 2013** to continue these payments ~~and will be submitted to CMS in FY 2013-14~~. Only hospitals that met eligibility requirements set forth in Section 14085.5 of the W&I Code will be eligible to participate.

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 Section14105.26 of the W&I Code. Two DP facilities began submitting claims and received payments in FY 2011-12.

SP 2	(PC-162)	X	X	Hospital Outpatient Supplemental Payments

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.

The reconciliation mandated by AB 915 against audited cost reports is scheduled to begin in FY ~~2013-14~~ **2014-15**. Adjustments to interim payments, or recoupment of overpaid

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				funds, are expected during FY ~~2013-14~~ **2014-15**. Reconciliation of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.
SP 3	(PC-167)	X	X	IGT Payments for Hospital Services 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	FFP for Local Trauma Centers 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	Certification Payments for DP-NFs 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. 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

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				increase the uncompensated costs eligible for supplemental reimbursement under this program. **The Department received CMS approval on December 20, 2013 to prospectively exempt DP/NF-B providers from the 10% payment reduction effective September 1,2013 for providers located in designated rural and frontier areas, and effective October 1, 2013 for the remaining DP/NF-B providers.**
SP 6	(PC-168)	X	X	Medi-Cal Reimbursements for Outpatient DSH 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.
SP 7	(PC-169)	X	X	Medi-Cal Reimbursements for Outpatient SRH 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.
SP 8	(PC-160)	~~X~~	X	Freestanding Outpatient Clinics 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. The non-federal match is paid from public funds of the participating facilities. Supplemental payments to freestanding outpatient clinics will be effective ~~retroactively beginning~~ **retroactive to** October 14, 2006.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				The SPA for freestanding outpatient clinics was approved August 8, 2012.
				Supplemental payments for freestanding, non-hospital based clinics are expected to begin October 2014.
SP 9	(PC-170)	X	X	State Veterans' Home Supplemental Payments
				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 public funds of the participating facilities. The SPA for state veterans' homes was approved March 3, 2011.
SP 10	(PC-163)	X	X	NDPH IGT Supplemental Payments
				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 11	(PC-158)	X		Hospital QAF – Hospital Payments

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:

- 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.

AB 188 (Chapter 645, Statues of 2009) established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			• 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 (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 12 (PC-93)	X	X	LIHP MCE Out-of-Network Emergency Care Services Fund SB 335 created 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.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
SP 13	(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. The supplemental reimbursement program will be retroactive to January 30, 2010. The SPA was approved on September 4, 2013.
SP 14	(PC-195)	X		Hospital QAF – Children's Health Care 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.
SP 15	(PC-198) (PC-159)		X	Extend Hospital QAF The current Hospital QAF program ~~will end~~ ended on December 31, 2013. ~~The Department is working with stakeholders and the Legislature to implement~~ **SB 239 (Chapter 657, Statutes of 2013) implements** a new fee program effective January 1, 2014. The new ~~program's sunset date will be~~ **program, which will provide additional funding to hospitals and for children's health care, sunsets on** December 2016.

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) Lawsuits/Claims*

Applicable F/Y
C/Y B/Y

a. Attorney Fees of $5,000 or Less

1. Faucher, Douglas M.	$5,000	
2. Ridgill Johnson Properties	**$3,161**	
Total **$8,161** ~~$5,000~~		
Fund Balance **$41,839** ~~$45,000~~	$50,000	$50,000

b. Provider Settlements of $75,000 or Less

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
13. AHMC Greater El Monte Community	**$2,949**
14. Catholic Healthcare West	**$11,335**
15. Daughters of Charity Health System	**$28,594**
16. Glendale Adventist Medical Center	**$8,264**
17. Children's Hospital & Research Center	**$8,299**
18. AHMC Greater El Monte Community	**$7,853**
19. Pioneers Memorial Healthcare District	**$13,651**
20. Daughters of Charity Health System	**$18,185**
21. CHA Hollywood Medical Center	**$5,640**
22. HCA Hospital Corporation of America	**$1,573**
23. CFHS Holdings Inc	**$5,135**
24. CHA Hollywood Medical Center	**$38,547**
25. Catholic Healthcare West	**$6,122**
26. Long Beach Memorial Center	**$6,089**
27. AHMC Greater El Monte Community	**$135**
28. CFHS Holdings Inc	**$11,974**
29. Cedars-Sinai Medical Center	**$4,960**
30. Dignity Health	**$2,283**
31. Alta Hospitals System	**$4,607**
32. Alta Hospitals System	**$1,795**
Total **$317,389** ~~$129,401~~	

Fund Balance **$1,282,611** ~~$1,470,599~~ $1,600,000 $1,600,000

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	Applicable F/Y B/Y
c. Beneficiary Settlements of $2,000 or Less		
1. Ledezma, Chang, Chikanov, Yu		$1,438
Total		$1,438
Fund Balance $13,562	$15,000	$15,000
d. Small Claims Court Judgments of $5,000 or Less		
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. Other Attorney Fees		
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
5. Maternal and Child Health Access		**$60,538**
6. Santa Clara Co. Health Authority		**$6,000,000**
Total	**$535,478** ~~$474,940~~	**$6,000,000**
f. Other Provider Settlements / Judgments		
Total		$0
g. Other Beneficiary Settlements		
Winton and Geraldine O'Neill		$17,000
Victims Compensation Board		$139,000
Total		$156,000

Amounts may exclude interest payments.

A 2 (PC-131) X X Notices of Dispute / Administrative Appeals – Settlements

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 Litigation-Related Services

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.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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	X	Litigation Settlements 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 2013-14 from ISTA Pharmaceuticals; Kmart Corp.; Medtronic; Pacific Health Corporation; Pfizer, Inc.; Ranbaxy USA, Inc.; Sanofi-Aventis U.S., Inc.; Johnson & Johnson; **Johnson & Johnson (Janssen);** Johnson & Johnson (Omincare); Victory Pharma; Seacliff Diagnostics Medical Group; Bioscrip; Dava Pharmaceuticals, Inc.; Senior Care Action Network; KV Pharmaceuticals; Amgen II**, Bio Med, Care Fusion; Endo Pharmaceuticals; Genzyme; Novatris; Omnicare; and Saint Helen's**.
A 5	(PC-NA)	X	X	AB 97 Injunctions This assumption has been moved to the "Time Limited/No Longer Available" section.
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.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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.

The Federal audit A-09-13-02012 identified claims within Central Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $2,953,936 FFP to CMS in FY 2014-15.

The Federal audit A-09-13-02019 identified claims within East Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $4,049,335 FFP to CMS in FY 2014-15.

The Federal audit A-09-13-02044 identified claims within Central Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $2,280,044 FFP to CMS in FY 2014-15.

OTHER REIMBURSEMENTS: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 1	(PC-NA)	X	X	FMAP Changes

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.

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.

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.

R 2	(PC-175)	X	X	Dental Contract

The dental rates are based on historical cost data and updated once a year.

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.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 3	(PC-125) (PC-153)	X	X	Dental Geographic Managed Care 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. In October 2012, the Department awarded contracts to three GMC dental plans, which took effect on January 1, 2013.
R 4	(PC-125) (PC-153)	X	X	Dental Managed Care within Medi-Cal Two-Plan Model Counties 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. The Department's contracts with six dental plans that provided services as voluntary PHPs in Los Angeles County-ended on June 30, 2013. In October 2012, the Department awarded new contracts to three PHP dental plans, which took effect on July 1, 2013.
R 5	(OA-15)	X	X	MIS/DSS Contract 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. Ongoing operation and maintenance of the MIS/DSS is accomplished through a multi-year contract with Optum Government Solutions, Inc. ~~(formerly Integris, Inc. DBA OptumInsight), which is effective through February 14, 2014. 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.~~ **The Department is in the process of conducting a competitive procurement and expects to award a new maintenance and operation (M&O)**

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				contract for MIS/DSS. The M&O contractor is expected to begin January 2015.
R 6	(PC-191)	X	X	Indian Health Services 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 *Federal Register*.
R 7	(OA-73)	X	X	Kit for New Parents 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.
R 8	(PC-176)	X	X	Developmental Centers/State Operated Small Facilities The Medi-Cal budget includes the estimated federal fund cost of the CDDS Developmental Centers (DCs) and two State-operated small facilities.
R 9	(OA-63)	X	X	CDDS Administrative Costs 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.
R 10	(PC-190) (OA-68)	X	X	CLPP Case Management Services 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.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 11	(PC-192)	X	X	Cigarette and Tobacco Products Surtax Funds

Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the *Orthopaedic Hospital* 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.

R 12	(OA-76)	X	X	California Health and Human Services Agency HIPAA Funding

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.

R 13	(OA-6)	X	X	EPSDT Case Management

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.

R 14	(OA-2) (OA-52)	X	X	CCS Case Management

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. The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate.

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.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 15	(OA-41)	X	X	Postage and Printing – Third Party Liability

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.

R 16	(OA-53)	X	X	TAR Postage

Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.

R 17	(PC-188)	X	X	HIPP Premium Payouts

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.

R 18	(PC-172)	X	X	Medicare Part A and Part B Buy-In

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.

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.

R 19	(OA-79)	X	X	PIA Eyewear Courier Service

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.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 20	(OA-67)	X	X	FFP for Department of Public Health Support Costs

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.

R 21	(PC-178)	X	X	ICF-DD Transportation and Day Care Costs - CDDS

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.

On April 15, 2011, CMS approved a SPA that allows FFP to be paid for these services retroactive back to July 1, 2007.

R 22	(PC-183)	X	X	Non-Contract Hospital Inpatient Cost Settlements

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.

R 23	(PC-144)	X	X	FQHC/RHC/CBRC Reconciliation Process

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:

Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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. 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. 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 & I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared. W & 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.
R 24	(OA-30)	X	X	<u>HIPAA Capitation Payment Reporting System</u> 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

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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. A new five-year contract was executed in July 2013 to address these system changes.
R 25	(OA-11) (PC-177) (PC-FI)	X	X	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 2011 through 2021. To qualify, health care providers must adopt, implement or upgrade (AIU), and meaningfully use 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. The Centers for Medicare and Medicaid Services (CMS) approved an IAPD Update (IAPD-U) on ~~December 11, 2012.~~ **September 9, 2013.** The authorization provides additional funds for meaningful use (MU) measures ~~specific to~~ **including** immunization registries **and provider technical assistance.** The Medical Fiscal Intermediary (FI) ~~began~~ **is** implementing ~~a~~ **the State Level Registry (SLR), 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~~ **adoption** 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)~~ **the SLR** payment functionality, allowing for more seamless and efficient participation and payment for eligible professionals (EPs) and eligible hospitals (EHs). CMS requires the Department to assess the usage of and barriers to AIU and MU by provider type~~; the~~ **. The** assessments require

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				multiple contractors~~.~~ **periodically over the course of the program.** The HITECH Act of 2009 allows a 90/10 FFP for administrative activities **related to the program**. The enhanced funding supports further advancement and maintenance of the EHR program.
R 26	(OA-38)	X	X	Encryption of PHI Data The Department acquired hardware, supplies and associated maintenance and support services that are necessary to ~~encrypt~~ **protect and secure** electronic data stored on backup ~~tapes~~ **systems. The Department continues to enhance infrastructure components to ensure that data stored on the backup systems is protected and secure**. The data on these ~~tapes~~ **systems** contain Medi-Cal beneficiary information that is considered confidential and/or protected health information (PHI) by federal and state mandates. The ~~encryption~~ **protection** of these ~~tapes~~ **systems** 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 27	(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

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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 28	(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 Equalization. The expenditures for the lead testing are in Medi-Cal's FFS base trends and this policy change adjusts the funding.
R 29	(PC-127) (PC-143)	X	X	Payment Deferral Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. Beginning in FY 2012-13, an additional checkwrite will be delayed at the end of each fiscal year. In addition to delaying a checkwrite, the Department is also delaying one month of managed care capitation rates beginning in FY 2012-13.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 30	(PC-173)	X	X	Part D–Phased-Down Contribution

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.

R 31	(OA-71)	X	X	CDPH I&E Program and Evaluation

AB 1762 (Chapter 301, Statutes of 2003) authorized the Department to require contractors and grantees under the Information and Education (I&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.

The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.

R 32	(PC-41)	X	X	Youth Regional Treatment Centers

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~~ **100% FMAP** for services provided to eligible American Indian Medi-Cal beneficiaries under the age of 21. **The per visit rate payable to Indian Health Services facilities is adjusted annually thorugh changes posted in the Federal Register.**

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
R 33	(PC-186)	X	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 tMedicare/Medi-Cal beneficiaries between calendar years 2009 through 2012.
R 34	(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 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. EffectiveJuly1, 2009, all GF was eliminated from the Maternal and Child Health programs. Local agencies continue to match Title XIX funds with Certified Public Expenditures.

OTHER RECOVERIES: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

OTHER RECOVERIES: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
RC 1	(PC-202)	X	X	Base Recoveries 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.
RC 2	(OA-22)	X	X	Medi-Cal Recovery Contracts 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.
RC 3	(PC-NA)	X	X	Anti-Fraud Activities This assumption has been moved to the “Fully Incorporated into Base Data/Ongoing” section.
RC 4	~~(PC-200)~~ (OA-46)	X	X	Medicare Buy-In Quality Review Project 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.
RC 5	(PC-NA)	X	X	Recovery of PCS/IHSS This assumption has been moved to the “Information Only” section.

FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 0.1 (PC-FI)		X	Medi-Cal Print Center Relocation and Optimization

The Department has directed Xerox to relocate and optimize the Medi-Cal Print and Distribution Center currently located in Rancho Cordova, CA to West Sacramento, CA. The current location is larger than needed and not easily accessible to Department staff. Moving the Medi-Cal Print and Distribution Center reduces future Department expenses and provides departmental staff better access to the Medi-Cal Print and Distribution Center, for purposes of providing contract oversight, auditing and print-on-demand projects. Project implementation is expected by June 30, 2014.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
FI 1	(PC-FI)	X	X	HIPAA – CA-MMIS

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.

The necessary work is associated with the following HIPAA regulations:

- Privacy (Completed)
- Transactions and Codes (Completed)
- Unique Employer Identifier (Completed)
- Security (In Progress)
- National Provider Identifier (Completed)
- Electronic Signature (Future Project)
- Enforcement (Completed)
- National Health Plan Identifier (Future Project)
- Claims Attachments (Future Project)
- First Report of Injury (Future Project)
- Transactions and Code Sets Revisions (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 (in terms of 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.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				CMS recently extended the October 1, 2013 deadline to October 1, 2014 for ICD-10.
FI 2	(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, 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. The plan outlines the effort necessary to perform the annual SS-A submission and updates the initial roadmap.
FI 3	(OA-19)	X	X	CA-MMIS System and Replacement Oversight 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

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				oversight activities, documentation of business rules, technical architecture, federal certification management, project management, transition management and independent validation & verification services during transition and replacement of the CA-MMIS system.
FI 4	(OA-18)	X	X	CA-MMIS System Replacement Other State Transition Costs 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 MEDS, EMBER, SCO, MIS/DSS, CalHEERS and PCES 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.
FI 5	(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.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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. BRE related costs 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).

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 a TAR Processing Center, and
- Consolidate existing Field Office Automation Group (FOAG) activities.

Phase II 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 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.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
				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 2014-15.
FI 6	(PC-FI)	X	X	<u>CA-MMIS Re-Procurement–HIPAA ICD-10 Legacy Enhancement</u> As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government issued a Final Rule on 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.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
FI 7	(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 continue to make additional modifications that are anticipated to result in additional costs carrying over into FY 2013-14.

FI 8	(PC-FI)	X	X	Rebate Accounting and Information System Hardware and Software Refresh

The Rebate Accounting and Information System (RAIS) supports invoicing of pharmaceutical drugs, physician-administered drugs, and medical supply rebates.

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 2013-14.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
FI 9	(PC-FI)	X	X	Point of Service Refresh

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.

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.

FI 10	(OA-47)	X	X	MIS/DSS Contract Reprocurement Services

~~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 contracted 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 ~~Feasibility Study Report~~ **Invitation for Bid (IFB) and Advance Planning Document (**APD**)** to achieve required state and federal level approvals. **The vendor will provide services through January 2015.**

FI 11	(PC-FI)	X	X	Clarity Software

The federal health reform initiatives require the Department to effectively and efficiently initiate, manage, monitor and report human and cost resources.

Clarity is a portfolio management tool designed for prioritization, efficiency, and analysis. This tool helps the Department manage the various business and 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.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 12 (PC-FI)	X		Additional CA-MMIS Office Space

The Department has consolidated 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 was completed in FY 2012-13. Final payment is anticipated to be made in FY 2013-14.

FI 13 (OA-31)	X	X	SDMC System M&O Support

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. The current contract ends on June 30, 2014. The Department plans to enter in a two-year contract beginning July 1, 2014, with two one-year optional extensions. **Additionally, due to an increase in claims volume and stricter reporting accountability, the Department plans to provide continuous support and system upgrades to the infrastructure components, which include reporting servers, back end hardware, software and support**.

FI 14 (OA-50)	X	X	Annual EDP Audit Contractor

The Department plans to procure an independent Certified Public Accounting firm to provide a contractually required annual 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.

FI 15 (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 Fiscal Intermediary (FI).

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 16 (PC-FI)	X	X	Provider Applications and Validation for Enrollment 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.
FI 17 (PC-FI)	X	X	Telephone Service Center – Customer Service Improvement Project 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.~~ **The Department has negotiated and executed an FI contract expanding the maximum band and setting a new rate per call.**

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
HO 1 (PC-FI)	X	X	Personalized Provider Directories

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.~~ **will continue implementing the pilot statewide during FY 2014-15.**

HO 2 (PC-FI)	X	X	Updates to Existing HCO Informing Materials

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:

- Current managed care requirements,
- New program needs and modifications,
  - Shifts from voluntary to mandatory eligibility requirements
  - Changes in plan or provider eligibility
- Compliance with Federal Health Care Reform law.

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.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
HO 3 (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 4 (PC-FI)	X	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~~ **March 11, 2014.** The Department will incur additional costs for these mailings.

FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 0.1 (OA-82)		X	Dental FI Re-Procurement IV&V

The Department has requested that the Dental Fiscal Intermediary Re-Procurement (DFIR) project obtain the services of an Independent Verification & Validation (IV&V) contractor to provide project oversight and governance. The IV&V contractor will provide management with an independent perspective on project activities and promote early detection of project/product variances. This allows the project to implement corrective actions to bring the project back in-line with agreed-upon expectations. Objectives of performing IV&V include:

- Facilitate early detection and correction of cost and schedule variances,
- Enhance management insight into process and product risk,
- Support project lifecycle process to ensure compliance with regulatory, performance, budget, and schedule requirements, and
- Validate the project's product and processes to ensure compliance with defined requirements.

The contractor is expected to begin July 2014 and will be funded 75% FF.

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 1 (PC-FI)	X	X	HIPAA – CD-MMIS

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	Medi-Cal Dental FI Contract Turnover

CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension began July 1, 2013 and goes through June 30, 2015. The Department ~~plans to~~ **will** develop a Planning Advance Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements.

The Department has instructed the FI contractor to resume turnover support services and all activities in accordance with the contract requirements. **Turnover activities, previously completed by the Dental FI, have to be redone. As a result, the Turnover bid price must be renegotiated. A change order will be submitted to implement this change**.

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.

DD 3 (PC-FI)	X	X	CD-MMIS Takeover by New Dental FI Contractor

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.

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. 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. 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

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			Takeover activities. 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. Takeover Activities for the new FI contractor are expected to begin October 1, 2014.
DD 4 (PC-FI)	X	X	Extension of the Current Medi-Cal Dental FI Contract CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The Department ~~plans to~~ **will** develop a Planning Advanced Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements.
DD 5 (OA-48)	X	X	Dental PAPD Project Manager 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%. Effective June 10, 2013, the Department procured a Certified Project Manager (CPM) to develop and obtain CMS approval of a PAPD. The Project Manager's responsibilities include: • Provide project management expertise, • Provide status reporting, and • Advise the Department to ensure CMS approval of the dental FI contract as an MMIS at the enhanced level.
DD 6 (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.

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 7 (OA-54)	X	X	Department of Managed Health Care Inter-Agency Agreement

SB 853 (Chapter 717, Statues 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.~~ **was executed in November 2013**.

DD 8 (OA-33)	X	X	Business Rules Extraction (BRE) Software and Services

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.

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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
	$ 510,265,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ 6,620,000	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,218,000	Freestanding Pediatric Subacute Quality Assurance Fee
	$ 383,441,000	Gross Premium Tax (AB 1422)
	$2,915,076,000	Hospital Quality Assurance Revenue Fund (4260-610-3158)
	$ ~~10,246,000~~**13,750,000**	Emergency Medical Air Transportation Fund (EMATA)
	~~$3,850,036,000~~**3,853,540,000**	Total
FY 2013-14:	$ ~~25,511,000~~**35,640,000**	ICF-DD Quality Assurance Fee
	$ 504,407,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~7,653,000~~**7,361,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,204,000	Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~783,818,000~~**798,599,000**	MCO Tax
	~~$3,364,557,000~~**3,664,901,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ ~~10,246,000~~**11,250,000**	Emergency Medical Air Transportation Fund (EMATA)
	~~$4,697,396,000~~**5,008,581,000**	Total
FY 2014-15:	$ ~~25,515,000~~**25,742,000**	ICF-DD Quality Assurance Fee
	$ 509,837,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~7,653,000~~**7,464,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ 1,218,000	Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~1,252,660,000~~**1,481,657,000**	MCO Tax
	$ ~~4,103,128,000~~**3,992,473,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)

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$	~~10,246,000~~**11,250,000**	Emergency Medical Air Transportation (EMATA) Fund
$	~~5,910,257,000~~**5,800,644,000**	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, Statues 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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9. Medi-Cal Inpatient Services for Inmates

AB 720 (Chapter 646, Statutes of 2013) authorizes the suspension of Medi-Cal benefits for all Medi-Cal eligible inmates, regardless of age. This new state law authorizes county boards of supervisors, in consultation with the county sheriff, to designate an entity or entities to act on behalf of county inmates and assist county jail inmates apply for a health insurance affordability program.

AFFORDABLE CARE ACT

10. 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 **the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county** ~~Medi-Cal and the uninsured~~ **indigent population**. **Option** 2 is redirection of 60% of a county's health realignment allocation plus **60% of the** maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) **as amended by Senate Bill 98 (Chapter 358, 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.~~ **AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider.**

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.

11. Disproportionate Share Hospital Reduction

The ACA reduction in the Disproportionate Share Hospital (DSH) allotments was to have gone into effect on October 1, 2013: instead, House Joint Resolution 59, passed by Congress and signed by the President on December 26, 2013, delays the reduction until October 1, 2015. The ACA ~~requires the aggregate,~~ nationwide reduction of State ~~Disproportionate Share Hospital (DSH)~~ **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.~~ **will occur in FY 2015-16.** The reduction for each state will be determined by CMS.

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BENEFITS

12. 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.

13. 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.

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

14. 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.

15. 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.

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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

16. 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.

17. 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

18. 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.

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1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

19. 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.

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.

20. 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

21. *Mission Hospital Regional Medical Center and Kaiser Foundation Hospitals et al. v. Douglas*

~~Plaintiffs are approximately~~ **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.

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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. 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, ~~80~~ **70** 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.~~ **Litigation has been stayed while some of the plaintiff hospitals decide whether to dismiss their participation in this lawsuit.**

22. *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.

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,

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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. 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 changes. ~~The Department is opposing this motion. A court judgment in this matter is expected later in FY 2013-14~~. **There was a court hearing on the plaintiffs' motion on December 13, 2013.**

On January 29, 2014, the trial court issued a decision in favor of the Department. The court ruled that the Department had reasonably determined based on its rate review that Medi-Cal beneficiaries had sufficient access to HHA services during 2001-2005 consistent with federal law.

23. *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 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~~ **to present** 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~~. **to present.** So far, there has been some additional discovery, but no other activity has occurred since the remand.

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24. *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 3** ~~Chapter 5~~, Statutes of **2008** ~~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 **with respect to only the 17 plaintiff hospitals**. ~~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 **United States** 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
- **On January 9, 2014, the Ninth Circuit issued a decision reversing and vacating the November 2009 injunction and remanded to the district court for further proceedings.** ~~Appellate briefing has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.~~

25. *Independent Living Center of Southern California Inc. et al. v. David Maxwell-Jolly*

This lawsuit challenges the 10% reduction required by AB~~X4~~ 5 (**Chapter 3,** ~~Chapter 5,~~ Statutes of **2008** ~~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,

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- 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. Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government.

26. 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.~~

- 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

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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.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government.

27. 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, **was** ~~has~~ been named as a co-defendant.

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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 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. **On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes.** ~~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 14th 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 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. **On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy change.** ~~The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.~~

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- *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 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 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. **On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes.** ~~The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.~~

- *California Medical Association et al. v. Douglas,*

  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 May 24, 2013, the Ninth Circuit

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denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. **On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes.** ~~The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.~~

28. *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, 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.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government.

29. *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

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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. 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. **This ruling became effective on September 26, 2013. Accordingly, beginning September 26, 2013, the Department must reimburse FQHCs and RHCs for podiatry, optometry and chiropractic services.**

~~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.~~

30. 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*
- *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 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. **Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The Department is in the process of finalizing the settlement agreement in the Santa Clara litigation.** ~~The Department is presently engaged in appellate mediation on damages and interest in the Santa Clara, Blue Cross, and Molina cases.~~

The Department is also currently in the process of settling a similar rates dispute with Medi-Cal Managed Care Plan Inland Empire Health Plan (IEHP). This case is currently

INFORMATION ONLY

pending before the Office of Administrative Hearings and Appeals and settlement discussions are on-going.

31. *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 appealed. On November 3, 2011, the Ninth Circuit Court of 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 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. The Department filed a motion to continue the stay, 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 submitted the SPA on November 1, 2013.** ~~The Department's opening brief is due November 12, 2013. Pharmacy staff continue to seek CMS approval of the SPA.~~

32. *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 March 31, 2012, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective 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.

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33. *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,
- 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.

34. *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.

35. *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).

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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. 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 **February 14, 2014** ~~October 24, 2013~~ at which the Department must either submit a revised report or show cause why it should be excused from doing so.

36. 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.

37. *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. **The writ of mandate was denied, and the petitioners filed a notice of appeal.**

38. *Saavedra, et al. v. Toby Douglas, California Department of Health Services Lawsuit*

In this writ litigation, petitioners allege that the Department improperly transitioned Seniors and Persons with Disabilities from the fee-for-service Medi-Cal delivery system into the managed care Medi-Cal delivery system by failing to appropriately respond to and process beneficiary requests to be exempted from the transition to managed care ("medical exemption requests"). Petitioners assert that the Department is applying improper standards in deciding medical exemption requests. The writ petition is scheduled for hearing on June 24, 2014.

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39. *Farrow v. Toby Douglas, Director of DHCS, et al.*

Petitioner is a disabled Medi-Cal beneficiary whose services were reduced when he reached the age of twenty-one (21). Petitioner alleges that the Department failed to provide petitioner with medically necessary in-home nursing services to which he was entitled under the Medi-Cal program, thereby placing him at risk of institutionalization in violation of state and federal anti-discrimination laws. Petitioner also alleges that the Department failed to comply with statutory and Constitutional due process requirements, including timely notice of termination of benefits, a pre-termination hearing, and aid pending a hearing decision. In addition, petitioner contends that the Department denied him a fair administrative hearing.

OTHER: REIMBURSEMENTS

40. 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.

41. 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 2012-13), the June 30, 2013 Medi-Cal accrual amounts were estimated to be $2.23 billion state General Fund, $5.09 billion federal funds, and $1.47 billion special fund, for a total of $8.79 billion.

42. 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.

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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.

43. 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 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

44. 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, however, the draft regulations are still under Departmental review.

45. Additional Personal Injury Recoveries

In *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, the United States Supreme Court held that a Medicaid agency's lien recovery from a Medicaid beneficiary's tort settlement is limited to the portion of the settlement that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. Then, in *Wos v. E.M.A.* (2013) 133 S.Ct. 1391, the U.S. Supreme Court held that states may not adopt a one-size-fits-all mechanism for allocating medical expenses, such as deeming a specific percentage of a tort settlement or award to be the medical expenses portion. Instead, states must have processes for determining and recovering only that portion that is attributable to medical expenses.

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In response to the *Ahlborn* ruling, California amended Welfare & Institutions (W&I) Code Section 14124.76 and enacted W&I Code Section 14124.785.

On December 26, 2013, H.J. Res. 59 (federal Budget Act) was signed into law. Section 202 of the Act addresses Medicaid third party liability. Section 202, effective October 1, 2014, essentially supersedes *Ahlborn* and *Wos* by allowing states to recover from the full amount of a beneficiary's tort settlement, instead of only the portion designated for medical expenses. The implementation date has been delayed to October 1, 2016. The nullification of the *Ahlborn* ruling is expected to increase savings for the Department.

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

46. Dental Program Utilization Controls Assessment

In an effort to improve the provider experience and to encourage further provider participation, the Department is evaluating program utilization controls and other administrative requirements to make the program more provider friendly while maintaining program integrity. The results of this effort are anticipated to be increased provider participation and potentially increased beneficiary utilization.

47. Enroll Registered Dental Hygienist as Billing Providers

The Department anticipates allowing the enrollment of Registered Dental Hygienists (RDH) who provide preventive dental services in public health programs as Denti-Cal billing providers will result in an increase in the following areas: access to care, utilization, and the Denti-Cal provider network. As outlined in the Medicaid Oral Health Learning Collaborative, it is Calfiornia's goal to increase by 10 percentage points the proportion of children enrolled in Medicaid ages 1-20 years who receive a preventive dental service over a five-year period. This policy change would help California move toward achieving that goal.

48. Teledentistry

The Department considers Teledentistry a cost-effective alternative to dental services provided in-person, predominantly in undeserved areas. Teledentistry is a way for dentists to deliver services to their patients that is similar to in-person care. The standard of care is the same whether the patient is seen in person or through the Teledentistry environment. This method of providing services would allow for improved access to care options for beneficiaries who typically experience access to care issues.

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY

1. 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 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 applied for and were awarded payment of attorneys' fees, which the Department paid in FY 2012-13.

2. Transition of Healthy Families Children to Medi-Cal

   Pursuant to AB 1494 (Chapter 28, Statutes of 2012), effective January 1, 2013, children subscribed in the HFP began 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.

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

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.

3. 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, 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).

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

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.

AFFORDABLE CARE ACT

BENEFITS

1. Hearing Aid Cap

   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.

2. Increased Federal Matching Funds for FPACT

   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.

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

1. Anti-Fraud Activities
   The Department expanded its anti-fraud activities.

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

1. 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.

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

- 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.

  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. 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.

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

AFFORDABLE CARE ACT

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

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
ACSs/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

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)
CCAH	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

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

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

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
OTLICP	Optional Targeted Low-Income Children's Program
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
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
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
VGT	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