

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2013-14

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<u>DRUG MEDI-CAL</u>				
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
<u>MENTAL HEALTH</u>				
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
<u>MANAGED CARE</u>				
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
<u>OTHER</u>				
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**

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

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<u>DRUG MEDI-CAL</u>				
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
<u>MENTAL HEALTH</u>				
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
<u>MANAGED CARE</u>				
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
<u>OTHER</u>				
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**

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

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

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE		
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	MAY TO APPROPRIATION	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**

NO.	POLICY CHANGE TITLE	2013-14 APPROPRIATION		NOV. 2013 EST. FOR 2013-14		MAY 2014 EST. FOR 2013-14		DIFFERENCE MAY TO APPROPRIATION	
		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**

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15	
		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**

NO.	POLICY CHANGE TITLE	NOV. 2013 EST. FOR 2014-15		MAY 2014 EST. FOR 2014-15	
		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**

NO.	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15	
		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**

NO.	POLICY CHANGE TITLE	MAY 2014 EST. FOR 2013-14		MAY 2014 EST. FOR 2014-15	
		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
<u>DRUG MEDI-CAL</u>	
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
<u>MENTAL HEALTH</u>	
69	SMHS FOR CHILDREN
70	SMHS FOR ADULTS
<u>MANAGED CARE</u>	
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
<u>OTHER</u>	
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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
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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
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TOTAL				\$35,049,000
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FY 2014-15

	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
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.

<u>FY 2013-14</u>	<u>TF</u>	<u>FF (Title XIX)</u>	<u>FF (Title XXI)</u>	<u>County</u>	<u>GF</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 63

These services are provided by certified providers under contract with the counties or with the State. Effective July 1, 2011, the funds to cover the non-federal share of cost were realigned to counties as County Funds (CF). Funding for the services is 50% 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.

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- 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.

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

<u>FY 2013-14</u>	<u>Caseload</u>	<u>UOS</u>	<u>Rates</u>	<u>Total</u>
Current				
DMC Perinatal	277	46.9	\$97.72	\$1,270,000
FY 2014-15				
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.

<u>Fiscal Year</u>	<u>Accrual</u>	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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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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.

<u>FY 2013-14</u>	<u>TF</u>	<u>FFP Title XIX</u>	<u>FFP Title XXI</u>	<u>CF</u>	<u>GF</u>
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
<u>FY 2014-15</u>	<u>TF</u>	<u>FFP Title XIX</u>	<u>FFP Title XXI</u>	<u>CF</u>	<u>GF</u>
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	<u>\$112,052,500</u>	<u>\$70,504,630</u>	<u>\$4,002,746</u>	<u>\$631,250</u>	<u>\$36,913,874</u>

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

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

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

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	<u>\$421,000</u>	<u>\$105,000</u>	<u>\$0</u>
FY 2012-13	\$63,513,000	\$15,878,000	\$0

Current

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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

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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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

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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
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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.

<u>FY 2013-14</u>	<u>TF</u>	<u>FFP Title XIX</u>	<u>FFP Title XXI</u>	<u>CF</u>	<u>GF</u>
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 XIX)	\$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 XXI)	\$118,526	\$118,526	\$0	\$0	\$118,526
Perinatal (Title XIX)	\$891,992	\$891,992	\$0	\$0	\$0
Perinatal (Title XXI)	\$17,508	\$17,508	\$0	\$0	\$0
Express Lane					
Regular (Title XIX)	\$1,816,536	\$1,816,536	\$0	\$0	\$0
Regular (Title XXI)	\$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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

	<u>TF</u>	<u>FFP</u>	<u>CF</u>
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)

	<u>TF</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
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)

	<u>TF</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
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	<u>TF</u>	<u>FFP</u>	<u>M-CHIP*</u>	<u>County</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)

	<u>Total</u>	<u>SD/MC</u>	<u>FFS Inpatient</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 2013-14, and 5,997,123 member months and \$450 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.

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:

		<u>TF</u>	<u>GF</u>	<u>FF</u>
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:

		<u>TF</u>	<u>GF</u>	<u>FF</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

		<u>TF</u>	<u>GF</u>	<u>FF</u>
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:

		<u>TF</u>	<u>GF</u>	<u>FF</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 OTLIPC 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 OTLIPC 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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:

<u>PACE Organization</u>	<u>County</u>	<u>Operational</u>
On Lok Lifeways	San Francisco	November 1, 1983
	Alameda	July 1, 2002
	Santa Clara	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 Svcs.	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 OnLok (SF, Alameda and Santa Clara)	\$67,861,000	18,797	1,566
St. Paul's PACE	\$62,931,000	14,663	1,222
Los Angeles Jewish Homes	\$15,109,000	4,196	350
CalOptima PACE	\$2,559,000	721	60
InnovAge	\$413,000	126	11
Redwood Coast	\$244,000	70	6
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 OnLok (SF, Alameda and Santa Clara)	\$78,493,000	21,671	1,806
St. Paul's PACE	\$70,741,000	16,626	1,385
Los Angeles Jewish Homes	\$26,602,000	7,294	608
CalOptima PACE	\$5,775,000	1,647	137
InnovAge	\$3,046,000	917	76
Redwood Coast	\$8,151,000	2,350	196
Central Valley Medical Services	\$1,451,000	380	32
Total Capitation Payments	\$1,881,000	516	43
Total FY 2014-15	\$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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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)		Capitation Rate	Average Monthly Eligibles	Total Funds
FY 2013-14				
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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, 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 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: $4,200 \times \$294.08 = \$1,235,000$

FY 14/15: $4,200 \times \$294.08 = \$1,235,000$

Medi-Cal Only:

FY 13/14: $5,400 \times \$1,664.04 = \$8,986,000$

FY 14/15: $5,400 \times \$1,664.04 = \$8,986,000$

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.

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
Dual	\$1,235,000	\$1,235,000
Medi-Cal Only	\$8,986,000	\$8,986,000
Recoupment	<u>-\$639,000</u>	<u>-\$1,160,000</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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: $817 \times \$1,848.75 = \$1,510,000$ TF (**\$755,000 GF**)

FY 2014-15: $780 \times \$1,848.75 = \$1,442,000$ 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 Eligibles-LTC policy change.

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 171

Reason for Change from Prior Estimate:

Updated expenditure data received from CDSS.

Methodology:

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

	<u>TF</u>	<u>FFP</u>	<u>CDSS GF/ County Share</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 2/3% each year until it reaches 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2011	\$100.77
2012	\$102.76
2013	\$103.70
2014	\$97.40
2015	\$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:

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

Reason for Change from Prior Estimate:

- 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.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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 FFS 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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

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

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

There is no change from prior estimate.

Methodology:

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

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

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

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

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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: $\$678.12 \times 293 \times 12 \text{ Months} = \$2,384,000 \text{ TF } (\$1,192,000 \text{ GF})$

FY 2014-15: $\$712.03 \times 290 \times 12 \text{ Months} = \$2,478,000 \text{ TF } (\$1,239,000 \text{ GF})$

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

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

DESCRIPTION

Purpose:

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	<u>\$1,799</u>	<u>\$1,799</u>
FY 2014-15	DHCS FFP	CDPH CLPP Fee Funds
Benefits Costs	<u>\$1,285</u>	<u>\$1,285</u>

Funding:

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

BASE RECOVERIES

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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	<u>TF</u>	<u>FFP Title XIX</u>	<u>FFP Title XXI</u>	<u>CF</u>
FY 2012-13	<u>(\$54,100,000)</u>	<u>(\$26,509,000)</u>	<u>(\$541,000)</u>	<u>(\$27,050,000)</u>
TOTAL FY 2013-14	<u>(\$54,100,000)</u>	<u>(\$26,509,000)</u>	<u>(\$541,000)</u>	<u>(\$27,050,000)</u>

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

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

	<u>FY 2013-14</u>	<u>FY 2014-15</u>
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