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MEDI-CAL PROGRAM REGULAR
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FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	1/1997
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$532,922,000	$571,452,000
- STATE FUNDS	$133,576,900	$143,234,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$532,922,000	$571,452,000
STATE FUNDS	$133,576,900	$143,234,200
FEDERAL FUNDS	$399,345,100	$428,217,800

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
Updated expenditure data through August 2014.

Methodology:
1. Use linear regressions on actual data from September 2011 to August 2014 for users, units per user, and dollars per unit.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1

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

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

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

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

	FY 2014-15		FY 2015-16	
Service Category	**TF**	**GF**	**TF**	**GF**
Physicians	$93,383,000	$23,406,000	$104,095,000	$26,091,000
Other Medical	$304,668,000	$76,365,000	$323,374,000	$81,053,000
County Outpatient	$1,212,000	$304,000	$1,276,000	$320,000
Community Outpatient	$2,531,000	$634,000	$2,716,000	$681,000
Pharmacy	$131,129,000	$32,867,000	$139,993,000	$35,089,000
Total*	**$532,922,000**	**$133,577,000**	**$571,452,000**	**$143,234,000**

Funding:

(Dollars in Thousands)

FY 2014-15

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$33,440	$16,720	$16,720
100% GF	4260-101-0001	$74,343	$74,343	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$425,139	$42,514	$382,625
Total*		**$532,922**	**$133,577**	**$399,345**

FY 2015-16

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$35,858	$17,929	$17,929
100% GF	4260-101-0001	$79,718	$79,718	$0
90% Family Planning / 10% GF	4260-101-0001/0890	$455,877	$45,588	$410,289
Total*		**$571,452**	**$143,234**	**$428,218**

**Amounts may differ due to rounding.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	1/2002
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	3

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$153,282,000	$162,970,000
- STATE FUNDS	$67,558,700	$71,495,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$153,282,000	$162,970,000
STATE FUNDS	$67,558,700	$71,495,500
FEDERAL FUNDS	$85,723,300	$91,474,500

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

Beneficiaries are screened through the Centers for Disease Control (CDC) and Family Planning, Access, Care, and Treatment (Family PACT) providers.

Reason for Change from Prior Estimate:
Updated eligibles data from February 2014 through July 2014 and updated expenditures data from January 2014 through June 2014.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2

Methodology:

1. There were 8,955 FFS and 3,382 managed care eligibles as of May 2014 (total of 12,337). 2,268 of the FFS eligibles were eligible for State-Only services.

2. 357 of the FFS eligibles were in Accelerated Enrollment as of May 2014.

3. Assume the State will pay Medicare and other health coverage premiums for an average of 541 beneficiaries monthly in FY 2014-15 and FY 2015-16. Assume an average monthly premium cost per beneficiary of $209.63.

   FY 2014-15: 541 x $209.63 x 12 months = $1,360,000* TF ($1,360,000 GF) *Rounded
   FY 2015-16: 541 x $209.63 x 12 months = $1,360,000* TF ($1,360,000 GF) *Rounded

4. FFS costs are estimated as follows:

(Dollars in Thousands)

	FY 2014-15		FY 2015-16	
	TF	GF	TF	GF
Federally Funded-Costs	$131,882	$46,159	$140,730	$49,255
State-Only Costs				
Services	$20,040	$20,040	$20,880	$20,880
Premiums	$1,360	$1,360	$1,360	$1,360
Total	**$153,282**	**$67,559**	**$162,970**	**$71,495**

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

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

Funding:

(Dollars in Thousands)

FY 2014-15:		GF	FF	TF
General Fund	4260-101-0001	$21,400	$0	$21,400
65% Title XIX / 35% GF	4260-101-0001/0890	$46,159	$85,723	$131,882
Total		**$67,559**	**$85,723**	**$153,282**

FY 2015-16:		GF	FF	TF
General Fund	4260-101-0001	$22,240	$0	$22,240
65% Title XIX / 35% GF	4260-101-0001/0890	$49,255	$91,475	$140,730
Total		**$71,495**	**$91,475**	**$162,970**

MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPL

REGULAR POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	7/2014
ANALYST:	Kim Elliott
FISCAL REFERENCE NUMBER:	1837

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$85,180,000	$99,663,000
- STATE FUNDS	$38,485,000	$44,631,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$85,180,000	$99,663,000
STATE FUNDS	$38,485,000	$44,631,000
FEDERAL FUNDS	$46,695,000	$55,032,000

DESCRIPTION

Purpose:
This policy change estimates the benefits cost for the Medi-Cal Access Program mothers with incomes between 200-300% of the federal poverty level (FPL).

Authority:
AB 99 (Chapter 278, Statutes of 1991)
SB 800 (Chapter 448, Statutes of 2013)

Interdependent Policy Changes:
PC 5 Medi-Cal Access Program Infants 250-300% FPL

Background:
Effective July 1, 2014, the Access for Infants and Mothers Program (AIM) was transitioned and renamed the Medi-Cal Access Program. The Medi-Cal Access Program covers pregnant women in families with incomes between 200-300% FPL. These pregnant women are subject to premiums fixed at 1.5% of their adjusted annual income.

The Medi-Cal Access Program is funded with Cigarette and Tobacco Surtax Revenues (Proposition 99), subscriber contributions, and Title XXI funding.

Reason for Change from Prior Estimate:
The May 2014 estimate assumed a monthly average of 6,707 pregnant women for FY 2014-15. Based on actual enrollment data through August 2014, the November 2014 estimate assumes a monthly average of 4,708 pregnant women for FY 2014-15.

Methodology:
1. Based on actual enrollment data from September 2012 to August 2014, the Department estimates an average monthly caseload of 4,708 in FY 2014-15 and 5,346 in FY 2015-16. Of the average monthly caseload, the Department estimates 547 deliveries per month in FY 2014-15 and 648 in FY 2015-16.

MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPL

REGULAR POLICY CHANGE NUMBER: 3

2. The Department estimates a per-member-per-month (PMPM) cost of $493.37 and a per-member-per-delivery (PMPD) cost of $10,204.10 in FY 2014-15 and FY 2015-16.

3. Medi-Cal Access Program subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total $3,039,000 in FY 2014-15 and $3,164,000 in FY 2015-16.

4. The Department assumes 10% of the monthly subscribers have a maternity only deductible exceeding $500 and are ineligible for FFP.

5. The total estimated costs for the Medi-Cal Access Program mothers in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)

FY 2014-15	**TF**	**SF**	**FF**
65% Title XXI FFP/35% Perinatal Insurance Fund	$76,513	$26,780	$49,733
100% Perinatal Insurance Fund	$8,667	$8,667	$0
Premiums	$0	$3,038	($3,038)
Total	**$85,180**	**$38,485**	**$46,695**

(Dollars in Thousands)

FY 2015-16	**TF**	**SF**	**FF**
65% Title XXI FFP/35% Perinatal Insurance Fund	$89,532	$31,336	$58,196
100% Perinatal Insurance Fund	$10,131	$10,131	$0
Premiums	$0	$3,164	($3,164)
Total	**$99,663**	**$44,631**	**$55,032**

Funding:
Perinatal Insurance Fund (4260-602-0309)
Title XXI FFP (4260-113-0890)

MEDI-CAL ADULT INMATE PROGRAMS

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$27,741,000	$49,009,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$27,741,000	$49,009,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$27,741,000	$49,009,000

DESCRIPTION

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

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
AB 720 (Chapter 646, Statutes of 2013)
SB 1399 (Chapter 405, Statutes of 2010)
SB 1462 (Chapter 837, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 authorizes the Department, counties, and the CDCR to claim FFP for inpatient hospital services to Medi-Cal or Low Income Health Program (LIHP) eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county. Effective April 1, 2011, the Department began accepting Medi-Cal applications from the California Correctional Health Care Services (CCHCS) for eligibility determinations for State inmates, retroactive to November 1, 2010. The Department will budget the FFP for services and CDCR administrative costs and CDCR will continue to budget the GF. Previously these services were paid by CDCR with 100% GF.

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

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4

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

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

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

Reason for Change from Prior Estimate:
Updated costs based on actual utilization claims and additional FY 2010-11 through FY 2013-14 retro dollars added for FY 2014-15 and FY 2015-16.

Methodology:

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

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

3. Based on utilization claims information, the average cost for an adult inpatient admission is $9,268 for both State and county inmates.

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

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

   300 monthly applications x 96% = 288 eligible State inmates

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

Monthly Applications (rounded)	FY 2014-2015					FY 2015-16				
Adults –Non ACA	288	x	20%	=	58	288	x	20%	=	58
Adults- ACA	288	x	80%	=	230	288	x	80%	=	230

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4

7. State inmate inpatient costs are estimated to be $26,545,000 ($13,680,500 FF) in FY 2014-15. FY 2010-2011 through FY 2013-2014 retro costs of $20,094,000 ($10,445,000 FF) constitutes the majority of this amount. The FF amount of $10,445,000 for retro claims includes ARRA rates. FY 2015-16 are estimated to be $6,451,000 ($3,225,500 FF).

FY 2014-15							**TF**	**FF**
(Dollars-rounded)								
Adults	58	x	12	x	$9,268	=	$6,451,000	$3,225,500
FY 2010-11 - FY 2013-2014 retro claims							$20,094,000	$10,455,000
Total							**$26,545,000**	**$13,680,500**

FY 2015-16							**TF**	**FF**
(Dollars-rounded)								
Adults	58	x	12	x	$9,268	=	$6,451,000	$3,225,500
Total							**$6,451,000**	**$3,225,500**

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

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

9. Assumes for FY 2014-15 and FY 2015-16, the county application split will be 20% for Medi-Cal and 80% for Optional Expansion ACA.

296 county applications x 20% = 59 eligible county inmates

10. County inmate inpatient inmate costs are estimated to be $6,562,000 for FY 2014-15. Due to a delay in contracting between participating counties and the Department, payments have been delayed and the Department expects to begin paying claims in February 2015. FY 2010-2011 through FY 2013-2014 retro claims are estimated at $49,294,000 TF. The FF amount of $26,009,000 for retro claims includes ARRA rates. The FY 2015-2016 costs are expected to be $55,856,000.

FY 2014-15							**TF**	**FF**
(Dollars-rounded)								
Adults	59	x	12	x	$9,268	=	$6,562,000	$3,281,000
Total							**$6,562,000**	**$3,281,000**

FY 2015-16							**TF**	**FF**
(Dollars-rounded)								
Adults	59	x	12	x	$9,268	=	$6,562,000	$3,281,000
FY 2010-11 - FY 2013-14 retro claims							$49,294,000	$26,009,000
Total							**$55,856,000**	**$29,290,000**

11. In FY 2014-15 and FY 2015-16, it is assumed the Department will process 25 applications annually

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4

for State Medical Parolees with verified citizenship. It is assumed these eligibles will receive long term care (LTC) services for fifteen months of continuous coverage.

12. State Medical Parolees inpatient costs are estimated to be the following with FF retro claims including ARRA rates.

FY 2014-15 (Dollars-rounded)					TF	FF
Adults	375	x	$12,663	=	$4,749,000	$2,374,500
FY 2010-11 - FY 2013-14 retro claims					$5,319,000	$2,706,000
Total					**$10,068,000**	**$5,080,500**

FY 2015-16 (Dollars-rounded)					TF	FF
Adults	375	x	$12,663	=	$4,749,000	$2,374,500
Total					**$4,749,000**	**$2,374,500**

13. In FY 2014-15 and FY 2015-16, it is assumed there will be 100 applications annually for county inmates granted Compassionate Release. It is assumed these eligibles will receive long term care (LTC) services for nine months of continuous coverage.

14. Implementation of the County Compassionate Release Program began January 1, 2013; however, the claims will not be reimbursed until February 1, 2015 due to a delay in contracting between counties and the Department. Total estimated costs for FY 2014-15 and FY 2015-16 are:

FY 2014-15 (Dollars-rounded)					TF	FF
Adults	900	x	$12,663	=	$11,397,000	$5,698,500
Total					**$11,397,000**	**$5,698,500**

FY 2015-16 (Dollars-rounded)					TF	FF
Adults	900	x	$12,663	=	$11,397,000	$5,698,500
FY 2012-13 - FY 2013-14 retro claims					$16,840,000	$8,420,000
Total					**$28,237,000**	**$14,118,500**

15. Total estimated Medi-Cal Inpatient Hospital Costs for Adults in FY 2014-15 and FY 2015-16 are:

(Dollars-rounded)

Summary	**FY 2014-15**		**FY 2015-16**	
State	TF	FF	TF	FF
Adults	$26,545,000	$13,680,500	$6,451,000	$3,225,500
Medical Parole	$10,068,000	$5,080,500	$4,749,000	$2,374,500
Total	$36,613,000	$18,761,000	$11,200,000	$5,600,000

MEDI-CAL ADULT INMATE PROGRAMS

REGULAR POLICY CHANGE NUMBER: 4

(Dollars-rounded)

	FY 2014-15		FY 2015-16	
County	**TF**	**FF**	**TF**	**FF**
Adults	$6,562,000	$3,281,000	$55,856,000	$29,290,000
Compassionate Release/ Probation	$11,397,000	$5,698,500	$28,237,000	$14,118,500
Total	$17,959,000	$8,979,500	$84,093,000	$43,408,500
State/County Total	$54,572,000	**$27,741,000**	$95,293,000	**$49,009,000**

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

MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	11/2013
ANALYST:	Kim Elliott
FISCAL REFERENCE NUMBER:	1797

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$24,082,000	$25,751,000
- STATE FUNDS	$8,428,700	$9,012,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$24,082,000	$25,751,000
STATE FUNDS	$8,428,700	$9,012,850
FEDERAL FUNDS	$15,653,300	$16,738,150

DESCRIPTION

Purpose:
This policy change estimates the benefits cost for the Medi-Cal Access Program linked infants with incomes between 250-300% of the federal poverty level (FPL).

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective November 1, 2013, Medi-Cal Access Program linked infants (formerly Acess for Infants & Mothers Program linked infants) transitioned into the Medi-Cal delivery system through a phase-in methodology. These infants are born to the women enrolled in the Medi-Cal Access Program. Similar to subscribers enrolled in the Targeted Low Income Children's Program (TLICP) with incomes above 150% of the FPL, subscribers enrolled in the Medi-Cal Access Program are subject to premiums.

Reason for Change from Prior Estimate:
Updated enrollment projections reflect an 18% decrease of 1st and 2nd year infants in FY 2014-15. This is based upon updated enrollment projections from PC 3 Medi-Cal Access Program Mothers 200-300% FPL.

Methodology:
1. The Department estimates 6,075 average monthly infants with family income between 250% and 300% FPL will enroll in FY 2014-15 and 5,646 in FY 2015-16.

2. The Department estimates an average monthly per-member-per-month (PMPM) cost of $343.34 in FY 2014-15 and $393.04 in FY 2015-16.

3. Medi-Cal Access Program subscribers are subject to monthly premiums. Premiums are estimated to total $948,000 in FY 2014-15 and $881,000 in FY 2015-16.

MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER: 5

4. The total estimated costs for the Medi-Cal Access Program linked infants in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
Benefits	$25,030	$8,760	$16,269
Premiums	($948)	($332)	($616)
Net	**$24,082**	**$8,429**	**$15,653**

FY 2015-16	**TF**	**GF**	**FF**
Benefits	$26,632	$9,321	$17,311
Premiums	($881)	($308)	($573)
Net	**$25,751**	**$9,013**	**$16,738**

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

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	4/2013
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1755

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$22,374,000	$31,546,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,374,000	$31,546,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$22,374,000	$31,546,000

DESCRIPTION

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

Authority:
AB 396 (Chapter 394, Statutes of 2011)
AB 720 (Chapter 646, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

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

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

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

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 6

Reason for Change from Prior Estimate:
FY 2011-12 through FY 2013-14 retroactive claims for the state juvenile inmate program will be paid in FY 2014-15. FY 2011-12 through FY 2013-14 retroactive claims for the county juvenile inmate program were higher than the prior estimate and will be paid in FY 2015-16. There was also an increase in the estimated number of county juveniles who will receive either psychiatric or other inpatient services.

Methodology:

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

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

3. Based on fee-for-service (FFS) cost data the average cost for a general acute care inpatient admission is $8,419 for both years. Based on the Mental Health Services Division information, the average inpatient psychiatric cost per client for those less than 21 years old is $6,528 for FY 2014-15 and $6,562 for FY 2015-16.

4. It is assumed the Department will process 10 applications per month for State juveniles and 495 applications per month for county juveniles with verified citizenship.

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

State Inmates	**FY 2014-15 & FY 2015-16**				
Psychiatric Services	10	x	80%	=	**8**
Inpatient Services (other)	10	x	20%	=	**2**

County Inmates	**FY 2014-15 & FY 2015-16**				
Psychiatric Services	495	x	80%	=	**396**
Inpatient Services (other)	495	x	20%	=	**99**

6. State juvenile costs are estimated to be $3,725,000 TF ($1,862,500 FF) in FY 2014-15 and $832,000 ($416,000 FF) in FY 2015-16.

(Dollars in Thousands)

FY 2014-15								
Retroactive claims							$2,896	$1,448
Psychiatric Services	8	x	12	x	$6,528	=	$627	$313
Inpatient Services (other)	2	x	12	x	$8,419	=	$202	$101
Total							**$3,725**	**$1,862**

FY 2015-16							**TF**	**FF**
Psychiatric Services	8	x	12	x	$6,562	=	$630	$315
Inpatient Services(other)	2	x	12	x	$8,419	=	$202	$101
Total							**$832**	**$416**

7. Implementation of the county juvenile inmate program began January 1, 2012; however, the FY

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 6

2011-12 through FY 2013-14 claims will not be reimbursed until FY 2015-16. County juvenile inmate costs are estimated to be $41,023,000 TF ($20,512,000 TF FF) in FY 2014-15.

(Dollars in Thousands)

FY 2014-15								TF	FF
Psychiatric Services	396	x	12	x	$6,528	=		$31,021	$15,511
Inpatient Services (other)	99	x	12	x	$8,419	=		$10,002	$5,001
Total								**$41,023**	**$20,512**

8. County juvenile costs are estimated to be $62,260,000 TF ($31,130,000 FF) in FY 2015-16.

(Dollars in Thousands)

FY 2015-16									
Retroactive claims								$21,075	$10,538
Psychiatric Services	396	x	12	x	$6,562	=		$31,183	$15,591
Inpatient Services (other)	99	x	12	x	$8,419	=		$10,002	$5,001
Total								**$62,260**	**$31,130**

9. Total estimated costs for Medi-Cal inpatient hospital and psychiatric services for State and county juvenile inmates in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)

	FY 2014-15		FY 2015-16	
Summary	**TF**	**FF**	**TF**	**FF**
State	$3,725	$1,862	$832	$416
County	$41,023	$20,512	$62,260	$31,130
Total	$44,748	**$22,374**	$63,092	**$31,546**

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

PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%

REGULAR POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	1/2015
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1873

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$17,636,000	$2,699,000
- STATE FUNDS	$8,818,000	$1,349,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,636,000	$2,699,000
STATE FUNDS	$8,818,000	$1,349,500
FEDERAL FUNDS	$8,818,000	$1,349,500

DESCRIPTION

Purpose:
This policy change estimates the costs of expanding full scope Medi-Cal coverage to pregnant women with income levels from 60% of the Federal Poverty Level (FPL) up to and including 138% of the FPL.

Authority:
SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions Code (W&I) 14005.22 and 14005.225
State Plan Amendment (SPA) 14-021
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Full scope Medi-Cal coverage is currently available to pregnant women with income levels up to 60% of the FPL. Pregnant women with incomes between 60% and 200% of the FPL currently receive pregnancy only coverage. Effective July 1, 2014, SB 857 authorized the expansion of full scope Medi-Cal coverage to pregnant women with incomes up to and including 138% of the FPL. SB 857 requires beneficiaries to enroll into a Medi-Cal managed care plan in the counties where one is available. For beneficiaries that reside in counties where Medi-Cal managed care is not available, services are provided via the fee-for-service (FFS) delivery system. The Department will seek federal approval from the Centers for Medicare & Medicaid Services (CMS) to implement the full scope income level changes for pregnant women. The Department submitted:

- A SPA to expand the income levels from 60% up to 109% of the FPL; and,
- An amendment to the BTR waiver to expand the income levels from above 109% up to 138% percent of the FPL.

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

PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%

REGULAR POLICY CHANGE NUMBER: 7

Methodology:

1. Prior to this change, women in the limited scope pregnancy-only program in Medi-Cal were all in the fee for service (FFS) delivery system. After the change they will be in managed care plans.
2. There is no material difference in cost between a limited scope pregnant eligible and a full scope pregnant eligible. However, there will be a difference in cash flow. While managed care payments are made prior to service delivery, FFS payments are made after service delivery. Therefore, there is a temporary increase while managed care payments are being made and FFS payments for prior services continue to be submitted and paid.
3. Assume implementation date is January 1, 2015.
4. For FY 2014-15 and FY 2015-16, the estimated per-member-per-month (PMPM) for the newly eligible pregnant women is $795.74.
5. For 66,906 eligible months, the estimated managed care capitation payments in FY 2014-15 are $53.2 million TF ($26.6 million GF).
6. For 133,479 eligible months, the estimated managed care capitation payments in FY 2015-16 are $106.2 million TF ($53.1 million GF).
7. FFS savings, on a cash basis, are estimated to be $35.6 million TF ($17.8 million GF) in FY 2014-15 and $103.5 million TF ($51.75 million GF) in FY 2015-16.
8. The total estimated costs in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
Managed Care Capitation Payments	$53,240	$26,620	$26,620
FFS Savings (lagged)	($35,604)	($17,802)	($17,802)
Total	**$17,636**	**$8,818**	**$8,818**

FY 2015-16	**TF**	**GF**	**FF**
Managed Care Capitation Payments	$106,215	$53,108	$53,107
FFS Savings (lagged)	($103,516)	($51,758)	($51,758)
Total	**$2,699**	**$1,350**	**$1,349**

Funding:

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

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 7/2014
ANALYST: Sandra Bannerman
FISCAL REFERENCE NUMBER: 1823

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,840,000	$1,661,000
- STATE FUNDS	$644,000	$581,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,840,000	$1,661,000
STATE FUNDS	$644,000	$581,000
FEDERAL FUNDS	$1,196,000	$1,080,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the County Health Initiative Matching (CHIM) fund program.

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

Interdependent Policy Changes:
Not Applicable

Background:
AB 495 created the CHIM fund program to provide health insurance coverage to low income children under the age of 19. The program has been administered by the Managed Risk Medical Insurance Board (MRMIB) and has been funded with county local funds received via intergovernmental transfers (IGTs) and matched with Title XXI federal funding. Currently, the CHIM program operates in three counties: San Francisco, San Mateo, and Santa Clara.

Effective July 1, 2014, SB 857 eliminated MRMIB and transferred its responsibilities to the Department. The bill also prohibits the Department from approving additional local entities for participation in the program. In addition, SB 857 requires local entities that were participating in the program on March 23, 2010, to continue to participate in the program, maintaining eligibility standards, methodologies, and procedures at least as favorable as those in effect on March 23, 2010 through September 30, 2019. If a county participating in the program on March 23, 2010 elects to cease funding the non-federal share of program expenditures during the Maintenance of Effort timeframe, the bill requires the Department to provide funding from the General Fund in amounts equal to the total non-federal share of incurred expenditures.

Reason for Change from Prior Estimate:
The increase in expenditures for FY 2014-15 is due to updated enrollment and expenditure data based on submittals from the counties. The increase also includes anticipated expenditures for the period of

COUNTY HEALTH INITIATIVE MATCHING (CHIM)

REGULAR POLICY CHANGE NUMBER: 8

January 2014 through June 2014 for San Mateo and Santa Clara county.

Methodology:

1. Santa Clara and San Mateo Counties elected not to provide funding for the non-federal share of the IGTs beginning January 1, 2014.

2. Assume San Francisco County will elect not to provide funding for the non-federal share of the IGTs beginning January 1, 2015.

FY 2014-15	TF	SF	FF
Title XXI FF	$1,076,000	$0	$1,076,000
Title XXI GF	$464,000	$464,000	$0
CHIM Fund*	$116,000	$116,000	$0
County Admin	$184,000	$64,000	$120,000
Total	**$1,840,000**	**$644,000**	**$1,196,000**

FY 2015-16	TF	SF	FF
Title XXI FF	$972,000	$0	$972,000
Title XXI GF	$523,000	$523,000	$0
County Admin	$166,000	$58,000	$108,000
Total	**$1,661,000**	**$581,000**	**$1,080,000**

Funding:

Title XXI FF (4260-113-0890)
Title XXI GF (4260-113-0001)
County Health Initiative Matching (CHIM) Fund (4260-113-3055)*

REFUGEES

REGULAR POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	7/1980
ANALYST:	Felicia Oropeza
FISCAL REFERENCE NUMBER:	14

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,001,000	$1,012,000
- STATE FUNDS	$1,001,000	$1,012,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,001,000	$1,012,000
STATE FUNDS	$1,001,000	$1,012,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

Authority:
Interagency Agreement #12-10028

Interdependent Policy Changes:

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

Under the Modified Adjusted Gross Income (MAGI) eligibility standards, all Refugee Cash Assistance eligibles and a portion of the Refugee Medical Assistance eligibles are now eligible for Medi-Cal.

Reason for Change from Prior Estimate:
Less refugees qualify for the Refugee Resettlement Program for their medical services.

Methodology:
1. Total refugee expenditures to be reimbursed by CDPH are estimated to be $1,001,000 in FY 2014-15 and $1,012,000 in FY 2015-16.

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

MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE

REGULAR POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	4/2015
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1874

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$740,000	$5,747,000
- STATE FUNDS	$259,100	$2,010,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$740,000	$5,747,000
STATE FUNDS	$259,100	$2,010,950
FEDERAL FUNDS	$480,900	$3,736,050

DESCRIPTION

Purpose:
This policy change estimates the costs of eliminating the 30 week pregnancy limit used in determining eligibility in the Medi-Cal Access Program (formerly the Access for Infants and Mothers (AIM) Program and AIM-Linked Infants Program).

Authority:
AB 99 (Chapter 278, Statutes of 1991)
AB 82 (Chapter 23, Statutes of 2013)
SB 857 (Chapter 31, Statutes of 2014), Welfare & Institutions Code (W&I) 15800-15806, 15810-15848.5

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2014, SB 857 eliminated the Managed Risk Medical Insurance Board (MRMIB) and transitioned the programs administered by MRMIB to the Department. The transition included the AIM and AIM-Linked Infants Program which was renamed the Medi-Cal Access Program. The program provides health insurance coverage to eligible pregnant women and their infants and is funded with Cigarette and Tobacco Surtax Revenues (Proposition 99), subscriber contributions, and Title XXI funding.

Pregnant women, residing in California, with incomes from 200% to 300% of the Federal Poverty Level (FPL) can participate in the Medi-Cal Access Program. The cost for pregnant women in the program is set at 1.5% of their adjusted annual income. Besides the income and residency requirements, pregnant women:

- Cannot be more than 30 weeks pregnant,
- Must be uninsured, have health insurance that does not cover maternity services, or have health insurance with a maternity-only deductible or copayment greater than $500.

MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE

REGULAR POLICY CHANGE NUMBER: 10

Medi-Cal Access Program linked infants with incomes from 200% to 250% of the FPL qualify for enrollment into the Targeted Low Income Children's Program (TLICP) and would be subject to monthly premiums. Infants born to mothers with incomes from 250% to 300% of the FPL would receive health coverage through the Medi-Cal Access Program.

With the transition of the Medi-Cal Access Program, the Department will no longer apply the 30 week pregnancy limit to eligibility determinations for pregnant women.

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

Methodology:

1. Assume implementation date is April 1, 2015.

2. Assume the applicants affected by the 30 week change are uninsured pregnant women that are beyond their 30th week of pregnancy.

3. For the Medi-Cal Access Program, the fiscal impact estimates increases in delivery and postpartum costs, prenatal costs, and costs of covering infants. Additional costs in the Medi-Cal program are attributed to increased enrollment of infants into the TLICP program.

4. Assume the annual per member costs are as follows:

	Annual Per Member Costs
Medi-Cal Access Program:	
Delivery and Postpartum Costs	$10,204.10
Prenatal Costs	$945.32
Infants	$6,583.47
Medi-Cal:	
TLICP Infants	$1,284.60

5. Assume approximately 441 applicants per year will be eligible for the Medi-Cal Access Program due to the 30 week change. 74% of infant costs are estimated in Medi-Cal TLICP and 26% of infant costs are estimated in the Medi-Cal Access Program. The annual costs in the Medi-Cal Access Program and Medi-Cal TLICP program are estimated to be:

Annual (Dollars in Thousands)	TF	GF	SF	FF
Medi-Cal Access Program:				
Delivery and Postpartum Costs	$4,497	$0	$1,574	$2,923
Prenatal Costs	$417	$0	$146	$271
Infants	$779	$273	$0	$506
Total	$5,693	$273	$1,720	$3,700
Medi-Cal:				
TLICP Infants	$432	$151	$0	$281
Total	**$6,125**	**$424**	**$1,720**	**$3,981**

*Amounts may differ due to rounding of applicants

MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE

REGULAR POLICY CHANGE NUMBER: 10

6. The estimated costs, on a cash basis, in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)

FY 2014-15	TF	GF	SF	FF
Medi-Cal Access Program:				
Delivery and Postpartum Costs	$543	$0	$190	$353
Prenatal Costs	$50	$0	$18	$33
Infants	$94	$33	$0	$61
Total	$688	$33	$208	$447
Medi-Cal:				
TLICP Infants	$52	$18	$0	$34
Total	**$740**	**$51**	**$208**	**$481**

FY 2015-16				
Medi-Cal Access Program:				
Delivery and Postpartum Costs	$4,219	$0	$1,477	$2,743
Prenatal Costs	$391	$0	$137	$254
Infants	$731	$256	$0	$475
Total	$5,341	$256	$1,614	$3,472
Medi-Cal:				
TLICP Infants	$406	$142	$0	$264
Total	**$5,747**	**$398**	**$1,614**	**$3,735**

Funding:
65% Title XXI / 35% GF (4260-113-001/0890)
65% Title XXI / 35% Perinatal Fund (4260-602-0309/4260-113-0890)

(Dollars in Thousands)

FY 2014-15	TF	GF	SF	FF
65% Title XXI / 35% GF	$146	$51	$0	$95
65% Title XXI / 35% Perinatal Insurance Fund	$594	$0	$208	$386
Total	**$740**	**$51**	**$208**	**$481**

FY 2015-16	TF	GF	SF	FF
65% Title XXI / 35% GF	$1,137	$398	$0	$739
65% Title XXI / 35% Perinatal Insurance Fund	$4,610	$0	$1,614	$2,997
Total	**$5,747**	**$398**	**$1,614**	**$3,735**

NEW QUALIFIED IMMIGRANTS

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$74,545,000	$74,545,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$74,545,000	$74,545,000
FEDERAL FUNDS	-$74,545,000	-$74,545,000

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA) specifies that FFP is not available for full-scope Medi-Cal services for qualified, nonexempt immigrants who enter the country after August 1996, for the first five years they are in the country. Currently, FFP is only available for emergency and pregnancy services. California provides full scope Medi-Cal services to eligible, nonexempt, qualified immigrants; however, non-emergency services that are not pregnancy related are 100% State funded.

Reason for Change from Prior Estimate:
Addition of new FFS data from January 2014-June 2014. Also, the percentage of managed care expenditures over FFS expenditures doubled based on new managed care data for non-emergency services.

Methodology:
1. Based on actual expenditure reports for the fee-for-service (FFS) non-emergency services costs of NQIs from January 2006 through June 2014, current year and budget year costs were projected.

NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 11

2. Based on the historical pattern of FFS versus managed care non-emergency service expenditures for the period of July 2012 through June 2014 (41.34%), the managed care totals for current year and budget year were projected.

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

4. The impact of Children's Health Insurance Program Reauthorization Act (CHIPRA) funding for full-scope Medi-Cal with FFP to eligible NQIs, who are children or pregnant women, is budgeted in the CHIPRA Medi-Cal for Children and Pregnant Women policy change.

5. The estimated FFP Repayment in FY 2014-15 and FY 2015-16:

(Dollars In Thousands)	**FY 2014-15**	**FY 2015-16**
FFS	$105,482	$105,482
Managed Care	$43,607	$43,607
Total	$149,089	$149,089
FFP Repayment	**$74,545**	**$74,545**

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

RESOURCE DISREGARD - % PROGRAM CHILDREN

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$80,419,200	-$80,419,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$80,419,200	-$80,419,200
FEDERAL FUNDS	$80,419,200	$80,419,200

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable.

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

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

Reason for Change from Prior Estimate:
The monthly managed care (MC) estimated eligibles decreased from 231,000 to 228,000 in FY 2014-15 and in FY 2015-16.The estimated monthly fee-for-service (FFS) eligibiles decreased from 52,000 to 13,000 in both fiscal years.

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 12

Methodology:

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

2. Average monthly FFS eligibles, which are included in the base, are estimated to be 13,000 in FY 2014-15 and in FY 2015-16. It is assumed total FFS expenditures will be $8,636,000 in both FY 2014-15 and in FY 2015-16.

3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 228,000 in FY 2014-15 and in FY 2015-16. It is assumed total Managed Care expenditures will be $527,500,000 in FY 2014-15 and in FY 2015-16.

4. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2014-15 and FY 2015-16.

Funding:

(Dollars in Thousands)

FY 2014-15		**TF**	**GF**	**FF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($536,128)	($268,064)	($268,064)
65 % Title XXI /35 % GF	4260-113-0001/0890	$536,128	$187,645	$348,483
Net Impact (rounded)		$0	**($80,419)**	$80,419

FY 2015-16		**TF**	**GF**	**FF**
50 % Title XIX /50 % GF	4260-101-0001/0890	($536,128)	($268,064)	($268,064)
65 % Title XXI /35 % GF	4260-113-0001/0890	$536,128	$187,645	$348,483
Net Impact (rounded)		$0	**($80,419)**	$80,419

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	7/2005
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1007

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$83,328,700	-$85,415,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$83,328,700	-$85,415,200
FEDERAL FUNDS	$83,328,700	$85,415,200

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

Methodology:
1. The cost of prenatal care for undocumented women is estimated to be $120,509,000 in FY 2014-15 and $123,719,000 in FY 2015-16.

2. Based on the estimated costs and 65% SCHIP FFP, the following amounts are budgeted for FY 2014-15 and FY 2015-16:

(Rounded)		
FY 2014-15:	$120,509,000 x .65 =	$78,331,000 FFP
FY 2015-16:	$123,719,000 x .65 =	$80,417,000 FFP

3. The estimated prenatal care cost for legal immigrants, who have been in the country for less than

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 13

five years, is $7,689,000 for FY 2014-15 and $7,689,000 for FY 2015-16.

(Rounded)		
FY 2014-15:	$7,689,000 x .65 SCHIP FFP =	$4,998,000 FFP
FY 2015-16:	$7,689,000 x .65 SCHIP FFP =	$4,998,000 FFP

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

FY 2014-15 Savings:	$78,331,000 + $4,998,000 =	**$83,329,000**
FY 2015-16 Savings:	$80,417,000 + $4,998,000 =	**$85,415,000**

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

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/2015
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1371

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	-$39,460,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	-$39,460,000
FEDERAL FUNDS	$0	$39,460,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that federal financial participation (FFP) is available for immigrants designated as “Qualified Immigrants” if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible qualified immigrants who have been in the US for less than five years, designated as “New Qualified Immigrants” (NQIs), and pays for nonemergency services with 100% State funds. FFP is only available for NQIs under the five year bar for emergency and pregnancy related services.

CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to NQIs and specified lawfully present immigrants who are children or pregnant women regardless of their date of entry into the US. Effective April 1, 2009, the Department began claiming FFP for NQI pregnant women and children.

Reason for Change from Prior Estimate:
Additional actuals for January 2014 –June 2014; revised pregnancy/children data reports for calendar year (CY) 2012. Placeholder claims have been or will be submitted for the period from July 2011 through June 2013; these will be resolved as of July 2015. The prior Estimate assumed that this claiming mechanism was in place and claiming had begun when it had not. Based on this information, adjustments were made to reflect this timing and show zero dollars for FY 2014-15 and dollars for FY

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 14

2011-13, FY 2013-14, FY 2014-15 and a partial amount for FY 2015-16.

Methodology:

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

2. Children

   Based upon quarterly claiming reports for 2013, 32.17% of expenditures for NQI services are for non-emergency services.

   FFS:
   Data reports for NQI children for CY 2012 services show fee-for-service (FFS) costs (including managed care carve-outs) of $9,331,000 for 0 to 18 year olds and $1,761,000 for 19 and 20 year olds.

   Non-emergency FFS expenditures for NQI children are (rounded):
   $9,331,000 x 32.17% non-emergency = $3,002,000 (0 to 18 year olds)
   $1,761,000 x 32.17% non-emergency = $567,000 (19 and 20 year olds)

   Managed Care:
   Data reports of NQI children managed care eligibles for calendar 2012 show 168,619 eligible months for 0 to 18 year olds and 18,749 for 19 and 20 year olds.

   The average capitation for the NQI children and pregnant women is assumed to be $122.01 PMPM in FY 2014-15 and for FY 2015-16.

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

   168,619 eligible months x $122.01 PMPM x 32.17% non-emergency = $6,618,600 (0 to 18 year olds) for FY 2014-15 and for FY 2014-15.

   18,749 eligible months x $122.01 PMPM x 32.17 % non-emergency = $736,000 (19 and 20 year olds) for FY 2014-15 and for FY 2015-16.

3. Pregnant Women

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

   FFS:
   Total FFS costs, including managed care carve-outs for pregnant women, are $36,698,000.

   The non-pregnancy related FFS expenditures for pregnant women are:
   $36,698,000 x 6.64% = $2,437,000 for both FY 2014-15 and 2015-16.

   Managed Care:
   Reports of NQI pregnant eligibles for CY 2012 show 69,887 eligible months.

   The average capitation for pregnant women is assumed to be $122.01 PMPM for FY 2014-15 and for FY 2015-16.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 14

Non-pregnancy services = 69,887 eligible months x $122.01 PMPM x 6.64% = $566,000 for FY 2014-15 and for FY 2015-16.

(Dollars in Thousands-rounded)

	FY 2014-15		FY 2015-16	
	Title XIX	Title XXI	Title XIX	Title XXI
	(50/50)	(65/35)	(50/50)	(65/35)
Children (0-18)				
FFS	$0	$3,002	$0	$3,002
MC	$0	$6,618	$0	$6,618
Children (19-20)				
FFS	$567	$0	$567	$0
MC	$736	$0	$736	$0
Pregnant Women				
FFS	$2,437	$0	$2,437	$0
MC	$566	$0	$566	$0
Total	**$4,306**	**$9,620**	**$4,306**	**$9,620**
GF	$2,153	$3,367	$2,153	$3,367
FFP	**$2,153**	**$6,253**	**$2,153**	**$6,253**

4. Total FY 2014-15 FFP of $8,406,000 offsets the General Fund cost of providing services to these eligibles.

5. Total FY 2015-16 FFP of $8,406,000 offsets the General Fund cost of providing services to these eligible. $4,203,000 (half) will be realized in FY 2015-16 and the other half in FY 2016-17.

6. Total estimated savings by total and by funding type:

FY 2014-15	**TF**	**GF**	**FF**
	$0	**$0**	**$0**

FY 2015-16	**TF**	**GF**	**FF**
FY 2011-12	-$0	-$8,851,000	$8,851,000
FY 2012-13	-$0	-$9,072,000	$9,072,000
FY 2013-14	-$0	-$8,928,000	$8,928,000
FY 2014-15	-$0	-$8,406,000	$8,406,000
FY 2015-16*	-$0	-$4,203,000	$4,203,000
	-$0	**-$39,460,000**	**$39,460,000**

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 14

FY 2015-16	Title XIX		Title XXI	
	GF	FF	GF	FF
FY 2011-12 (retro)	($1,812,500)	$1,812,500	($7,038,500)	$7,038,500
FY 12-13 (retro)	($1,991,000)	$1,991,000	($7,081,000)	$7,081,000
FY 2013-14	($2,254,000)	$2,254,000	($6,674,000)	$6,674,000
FY 2014-15	($2,153,000)	$2,153,000	($6,253,000)	$6,253,000
Sub Total	($8,210,500)	$8,210,500	($27,046,500)	$27,046,500
FY 2105-16*	($1,076,500)	$1,076,500	($3,126,500)	$3,126,500
Grand Total	**($9,287,000)**	**$9,287,000**	**($30,173,000)**	**$30,173,000**

*Assumes half of FY 2015-16 savings.

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

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	11/2012
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1776

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$815,000	-$1,301,000
- STATE FUNDS	-$407,500	-$650,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	44.91 %	29.72 %
APPLIED TO BASE		
TOTAL FUNDS	-$449,000	-$914,300
STATE FUNDS	-$224,490	-$457,170
FEDERAL FUNDS	-$224,490	-$457,170

DESCRIPTION

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

Authority:
Welfare & Institutions Code, section 14053

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
The Department established the Incarceration Verification Program (IVP) to improve the process of identifying individuals ineligible for Medi-Cal benefits due to incarceration. Improving verification and identification capabilities lowers program expenditures and yields cost savings through the discontinuance of ineligible beneficiaries. All identified inmates will lose Medi-Cal eligibility or have their eligibility suspended; however, some will remain eligible for coverage of inpatient services provided off the grounds of the correctional facility in the Medi-Cal Inmate Eligibility program for inpatient care.

Reason for Change from Prior Estimate:
There was an increase in the number of discontinued managed care (MC) beneficiaries and higher MC rates.

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

2. Based on monthly reports of IVP and California Department of Corrections and Rehabilitation Division of Juvenile Justice (CDCR-DJJ) matches, it is estimated that a total of 552 managed care beneficiaries will be discontinued from Medi-Cal in FY 2014-15 and FY 2015-16.

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 15

3. Total managed care savings is estimated to be $815,000 TF in FY 2014-15, and $1,301,000 TF in FY 2015-16.

4. In FY 2014-15, it is estimated that 44.91% of the managed care savings is captured in the base trends. In FY 2015-16, it is estimated that 29.72% of the managed care savings is captured in the base trends.

FY 2014-15	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($815,000)**	44.91%	($366,000)

FY 2015-16	**TF**	**% in Base**	**Savings in Base**
Managed Care Savings	**($1,301,000)**	29.72%	($387,000)

5. Total estimated savings not in the base trends:

FY 2014-15	**TF**	**GF**
Total Savings	**($449,000)**	**($224,500)**

FY 2015-16	**TF**	**GF**
Total Savings	**($914,000)**	**($457,000)**

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

PARIS-VETERANS

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$4,654,000	-$5,515,000
- STATE FUNDS	-$2,327,000	-$2,757,500
PAYMENT LAG	0.9417	0.9312
% REFLECTED IN BASE	58.45 %	84.38 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,821,000	-$802,200
STATE FUNDS	-$910,500	-$401,090
FEDERAL FUNDS	-$910,500	-$401,090

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14124.11

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

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

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

Reason for Change from Prior Estimate:
Updated FY 2014-15 and FY 2015-16 discontinuances and corresponding fee-for-service (FFS) and managed care (MC) rates.

Methodology:
1. The DHCS currently is operating PARIS-Veterans in 11 counties for the Outreach program; 58 counties utilize the High Income Cost Avoidance and Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA) programs.

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 16

2. Savings for PARIS-Veterans is for eligibles in MC and FFS.

3. It is estimated program expenditures will be reduced for 161 veterans in FY 2014-15 and FY 2015-16, of which 92 will be managed care and 69 will be FFS. DHCS expects that savings will continue in the budget year through discontinuances, share of cost modifications, and cost avoidance by identifying Other Health Coverage (OHC).

4. Monthly savings was calculated by dividing the annual discontinuances by the quarters and then multiplying the managed care weighted average cap rates and the fee for service average costs with the corresponding discontinuances.

5. Average savings on a PMPM basis will be $293.70 in FY 2014-15 and in FY 2015-16. There is an increase in the lower cost number of medically needy and disabled discontinuances.

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

TLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	7/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1879

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$69,083,000	-$70,507,000
- STATE FUNDS	-$24,179,050	-$24,677,450
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$69,083,000	-$70,507,000
STATE FUNDS	-$24,179,050	-$24,677,450
FEDERAL FUNDS	-$44,903,950	-$45,829,550

DESCRIPTION

Purpose:
This policy change estimates the premium revenue associated with the Targeted Low Income Children's Program (TLICP).

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

Interdependent Policy Change:
Not Applicable

Background:
Effective January 1, 2013, Healthy Families Program (HFP) subscribers began a transition into Medi-Cal through a phase-in methodology. The Department implemented TLICP, which covers children who would have been previously enrolled in HFP. TLICP covers children with family incomes between 100% of the federal poverty level (FPL) and 250% of the FPL. Those children with family incomes over 150% FPL will be required to pay monthly premiums for coverage.

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

Methodology:

1. The Department estimates in FY 2014-15 there will be 952,249 average monthly TLICP eligibles and 971,766 in FY 2015-16. Based on 2011 HFP data, 61.84% of the TLICP population has family incomes over 150% of the FPL.

2. In FY 2014-15, the Department estimates there are 7,066,479 member months subject to monthly premiums and 7,211,312 in FY 2015-16.
   FY 2014-15: 952,249 x 12 months x 61.84% = **7,066,479** member months
   FY 2015-16: 971,766 x 12 months x 61.84% = **7,211,312** member months

TLICP PREMIUMS

REGULAR POLICY CHANGE NUMBER: 17

3. Children under 1 years old, and American Indians are exempt from paying monthly premiums. The Department estimates the following member months are exempt from the TLICP premium calculation:

	FY 2014-15	FY 2015-16
Total Exempt Member Months	144,776	147,136

4. The Department provides discounts to individuals who prepay, establish automatic electronic fund transfers (EFT), and those families with multiple children. The Department estimates the following member months reduce total premium eligible member months:

	FY 2014-15	FY 2015-16
Discount Program	900,976	919,442
Delinquent Premiums	706,648	721,131
Total Loss of Premium Member Months	1,607,624	1,640,573

5. The net member months for the TLICP premium calculation are:

	FY 2014-15	FY 2015-16*
Eligible Member Months	7,066,479	7,211,312
Exempt Member Months	(144,776)	(147,136)
Loss Member Months	(1,607,624)	(1,640,573)
*Net Member Months	**5,314,080**	**5,423,602**

*Total Net Member Months may differ due to rounding.

6. The monthly premium requirement for children with incomes between 150% to 250% FPL is $13.

7. The total estimated premium revenue for TLICP are:

(Dollars In Thousands)	TF	GF	FF
FY 2014-15	**($69,083)**	**($24,179)**	**($44,904)**
FY 2015-16	**($70,507)**	**($24,677)**	**($45,830)**

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

ACA OPTIONAL EXPANSION

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$12,583,273,000	$14,319,656,000
- STATE FUNDS	$7,318,000	$7,485,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,583,273,000	$14,319,656,000
STATE FUNDS	$7,318,000	$7,485,000
FEDERAL FUNDS	$12,575,955,000	$14,312,171,000

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 21 Payments to Primary Care Physicians
PC 69 SMHS for Adults
PC 62 Intensive Outpatient Treatment Services
PC 63 Narcotic Treatment Program
PC 64 Outpatient Drug Free Treatment Services
PC 65 Residential Treatment Services
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and mandatory expansions.

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 18

A percentage of the Medi-Cal expansion population will need substance use disorder treatment services and/or mental health services. Expenditures for county mental health services are included in the PC 69 SMHS for Adults policy change.

Reason for Change from Prior Estimate:
There have been several changes. First, the Department revised the caseload projections based on enrollment data through August and updated the per-member-per-month (PMPM) costs. Updates to the PMPM include revising the managed care capitated rates and using the FY 2014-15 adult Delta Dental rate. The new Delta Dental rate includes the restoration of select dental benefits, where in May these benefits were budgeted separately. Additionally, the FY 2014-15 costs related to the primary care physician (PCP) rate increase are now budgeted in the PC 21 Payments to Primary Care Physicians policy change. The FY 2014-15 carve-outs related to the specialty mental health services (SMHS) are now budgeted in the PC 69 SMHS for Adults policy change. Lastly, the Managed Care Organization (MCO) tax revenue is now budgeted in the MCO tax policy changes (PC 114, PC 134, and PC 135).

Methodology:

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

2. The Department estimates 1,995,243 newly eligible beneficiaries will enroll in Medi-Cal by June 2015 and grow to 2,025,098 by June 2016. The Department assumes 76.1% of the beneficiaries by June 2015 will be covered by a Medi-Cal managed care plan. By June 2016, the Department assumes managed care enrollment for the newly eligible population will increase to 90.1%.

3. In FY 2014-15, the estimated weighted average per-member-per-month (PMPM) for the newly eligible population is $619.31. The PMPM includes managed care capitation rates, managed care carve-outs, and dental. In FY 2014-15, the estimated fee-for-service (FFS) PMPM for the newly eligible population is $261.54 (unlagged). The Department assumes an ongoing 5% inflation factor for PMPM costs.

4. The ACA requires Medi-Cal to increase the primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department receives 100% FFP for the additional incremental increase in Medi-Cal rates. FY 2014-15 costs related to the increase are now budgeted in PC 21 Payments to Primary Care Physicians policy change.

5. The total estimated costs for the ACA optional expansion in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
Newly Eligible Costs	$12,318,600	$7,318	$12,311,282
Long Term Support Services (LTSS)	$264,673	$0	$264,673
Total	**$12,583,273**	**$7,318**	**$12,575,954**

(Dollars in Thousands)

FY 2015-16	**TF**	**GF**	**FF**
Newly Eligible Costs	$14,032,724	$7,485	$14,025,239
Long Term Support Services (LTSS)	$286,932	$0	$286,932
Total	**$14,319,656**	**$7,485**	**$14,312,171**

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 18

Funding:

(Dollars In Thousands)

FY 2014-15:	**TF**	**GF**	**FF**
100% Title XIX Federal Share (4260-101-0890)	$12,575,954	$0	$12,575,954
100% GF (4260-101-0001)	$7,318	$7,318	$0
Total	**$12,583,273**	**$7,318**	**$12,575,954**

FY 2015-16:	**TF**	**GF**	**FF**
100% Title XIX Federal Share (4260-101-0890)	$14,312,171	$0	$14,312,171
100% GF (4260-101-0001)	$7,485	$7,485	$0
Total	**$14,319,656**	**$7,485**	**$14,312,171**

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	10/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1785

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,603,845,000	$2,020,469,000
- STATE FUNDS	$762,365,400	$961,388,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	69.20 %	64.60 %
APPLIED TO BASE		
TOTAL FUNDS	$493,984,300	$715,246,000
STATE FUNDS	$234,808,540	$340,331,480
FEDERAL FUNDS	$259,175,720	$374,914,550

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 21 Payments to Primary Care Physicians
PC 62 Intensive Outpatient Services
PC 63 Narcotic Treatment Program
PC 64 Outpatient Drug Free Treatment
PC 65 Residential Substance Abuse Services
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and mandatory expansions.

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 19

Reason for Change from Prior Estimate:
There have been several changes. First, the Department revised the caseload projections based on actual enrollment data through August and updated the per-member-per-month (PMPM) costs. Updates to the PMPM include revising the managed care capitated rates and using the FY 2014-15 Delta Dental rates for children and adults. The new Delta Dental rate includes the restoration of select dental benefits for adults, where in May these benefits were budgeted separately. Updates to the caseload include adding new MAGI aid codes into the base trends through August, which has created a percent in base for this policy change. Additionally, the FY 2014-15 costs related to the primary care physician (PCP) rate increase are now budgeted in the PC 21 Payments to Primary Care Physicians policy change. Lastly, the Managed Care Organization (MCO) tax revenue is now budgeted in the MCO tax policy changes (PC 114, PC 134, and PC 135).

Methodology:

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

2. Since January, the Department has experienced significant growth in Medi-Cal as result of the eligibility simplification and ACA outreach efforts.

3. The Department estimates an additional 1,074,231 eligibles will enroll in Medi-Cal by June 2015 and grow to 1,092,088 by June 2016. The Department estimates 69.2% of the additional growth in FY 2014-15 is now captured in the base trends and 64.6% in FY 2015-16.

4. Assume 71% of the beneficiaries in FY 2014-15 and FY 2015-16 will be covered by a Medi-Cal managed care plan.

5. In FY 2014-15, it is estimated the weighted average PMPM cost for adults currently eligible but not enrolled is $156.39. The estimated PMPM cost for children eligible but not enrolled is $102.74. Both PMPM costs include: managed care capitation rates, managed care carve-outs, and dental. In FY 2014-15, the estimated unlagged FFS PMPM cost for children is $143.20 and $260.65 for adults. The Department assumes an ongoing 5% inflation factor for PMPM costs.

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

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

(Dollars in Thousands)	FY 2014-15		FY 2015-16	
	TF	GF	TF	GF
Currently Eligible but Uninsured (0-64)				
Adult population (19-64)	$632,751	$316,376	$828,116	$414,058
Percent of Poverty (0-18 years)	$595,738	$297,869	$742,362	$371,181
TLICP (0-18 years)	$238,015	$83,305	$296,407	$103,743
Subtotal (rounded)	$1,466,505	$697,550	$1,866,886	$888,982
Foster Care Expansion	$30,223	$15,112	$31,734	$15,867
Dental Capitation	$107,117	$49,704	$121,849	$56,540
Total	**$1,603,845**	**$762,365**	**$2,020,469**	**$961,388**

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 19

Funding:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$1,340,131	$670,065	$670,065
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$263,714	$92,300	$171,414
Total	**$1,603,845**	**$762,365**	**$841,480**

FY 2015-16	**TF**	**GF**	**FF**
50% Title XIX FFP / 50% GF (4260-101-0001/0890)	$1,694,828	$847,414	$847,414
65% Title XXI FFP / 35% GF (4260-113-0001/0890)	$325,641	$113,974	$211,667
Total	**$2,020,469**	**$961,388**	**$1,059,081**

ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	2/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1834

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,309,980,000	$1,222,964,000
- STATE FUNDS	$14,913,750	$15,245,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,309,980,000	$1,222,964,000
STATE FUNDS	$14,913,750	$15,245,750
FEDERAL FUNDS	$1,295,066,250	$1,207,718,250

DESCRIPTION

Purpose:
This policy change estimates the benefit cost of additional Medi-Cal eligibles through use of the Express Lane option for enrollment.

Authority:
SBx1 1 (Chapter 4, Statutes of 2013)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138% of the federal poverty level (FPL). The ACA expansion includes:

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

The Centers for Medicare and Medicaid Services (CMS) has provided options for the states to facilitate enrollment into Medicaid programs. These Express Lane Enrollment options would help alleviate the influx of applications on the new enrollment system for ACA. This is accomplished by giving Medicaid eligibility to targeted groups of individuals without the need to conduct a separate Modified Adjusted Group Income (MAGI) based determination for the first twelve months. The assumption is that these targeted groups would, with a high degree of certainty, be eligible for Medi-Cal if a MAGI-based eligibility were conducted.

ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 20

One of the CMS options is a waiver that would simplify the enrollment process for those receiving Supplemental Nutrition Assistance Program (SNAP) benefits. In California this program is known as CalFresh. Another option is a waiver that would address enrollment for parents based upon the children's income eligibility. SBx1 1 requires the Department to seek federal waivers to implement these two options.

Reason for Change from Prior Estimate:
The Department added a second mailing for targeted CalFresh populations. Additionally, the estimated take-up from the first mailing was revised using actual enrollment through August in MEDS.

Methodology:

1. Based upon special reports comparing Medi-Cal eligibles to other program eligibles, the following is the estimated number of enrollees who could potentially be eligible for Medi-Cal after implementation of the ACA on January 1, 2014:

Targeted Groups:	**1st Mailing**	**2nd Mailing**
Childless Adults	580,000	255,000
Children	154,000	68,000
Parents/Caretaker Relatives	150,000	65,000
Total	**884,000**	**388,000**

2. Of those potentially eligible, it is assumed 8.8% will enroll in Medi-Cal through either the ACA mandatory expansion or the ACA optional expansion.
   1,272,000 potential eligibles x (100% - 8.8%) overlap = 1,160,064 eligibles

3. Of the remaining 1,160,064, it is assumed that 19.24% of the potential eligibles will take-up Medi-Cal coverage.
   1,160,064 potential eligibles x 19.24% take-up = 223,217 eligibles

4. Assume Express Lane notifications for the first targeted population were sent out in February and April 2014. Assume the Express Lane notifications for the second targeted population will be sent out in October 2014. Each population is assumed to phase-in over 5-months following the mailing of the notification.

5. Based upon the above assumptions, total member months of new eligibles will be:

Member Months	**FY 2014-15**	**FY 2015-16**
Adults	1,984,410	1,836,598
Children	311,574	289,104
Parents	13,599	14,460
Total	**2,309,583**	**2,140,163**

ACA EXPRESS LANE ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 20

6. The PMPM costs include managed care, dental, long-term supportive services (for Adults and Parents) and fee-for-service/other services that are not included in the managed care capitation. The average PMPM, including appropriate payment lags, is estimated to be:

PMPM	FY 2014-15	FY 2015-16
Adults	$640.44	$643.96
Children	$97.70	$107.70
Parents	$640.44	$643.96

7. CalFresh adults and 75% of the CalFresh parents are assumed to qualify for ACA enhanced federal funding. The remaining 25% of CalFresh parents are assumed to qualify for regular Title XIX 50/50% federal funding.

8. An estimated 30% of children are assumed to qualify for enhanced Title XXI 65% funding, while the rest qualify for Title XIX 50% funding.

(In Thousands)	**CalFresh Adults**	**CalFresh T21 Children**	**CalFresh T19 Children**	**CalFresh Parents**	**TF**	**GF**
FY 2014-15	$1,270,886	$9,115	$21,270	$8,709	**$1,309,980**	**$14,914**
FY 2015-16	$1,182,703	$9,285	$21,664	$9,312	**$1,222,964**	**$15,246**

Funding:
(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
100% Title XIX FFP (4260-101-0890)	$1,277,418	$0	$1,277,418
65% Title XXI /35% Title XXI (4260-113-0890/0001)	$9,115	$3,190	$5,925
50% Title XXI /50% Title XIX (4260-113-0890/0001)	$23,447	$11,724	$11,724
Total	**$1,309,980**	**$14,914**	**$1,295,066**

FY 2015-16	**TF**	**GF**	**FF**
100% Title XIX FFP (4260-101-0890)	$1,189,687	$0	$1,189,687
65% Title XXI /35% Title XXI (4260-113-0890/0001)	$9,285	$3,250	$6,035
50% Title XXI /50% Title XIX (4260-113-0890/0001)	$23,992	$11,996	$11,996
Total	**$1,222,964**	**$15,246**	**$1,207,718**

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER:	21
IMPLEMENTATION DATE:	11/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1659

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$978,387,000	$0
- STATE FUNDS	$25,739,000	$0
PAYMENT LAG	0.9990	1.0000
% REFLECTED IN BASE	4.63 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$932,154,600	$0
STATE FUNDS	$24,522,740	$0
FEDERAL FUNDS	$907,631,860	$0

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

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

The primary care service codes subject to ACA provisions are evaluation and management (E&M) codes: 99201-99499 and immunization administration procedure codes 90460, 90461, 90471, 90472, 90473, and 90474. This provision extends to any subsequent modifications to the coding of these services.

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

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 21

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

Reason for Change from Prior Estimate:

- This Estimate includes the fiscal impact due to ACA expansion.
- Updated program data.

Methodology:

1. Implementation began November 4, 2013, and the increase was retroactive to January 1, 2013.

2. FY 2012-13 Medi-Cal FFS paid claims data for certain E&M and immunization administration procedure codes was used to study the Medi-Cal payment rate and utilization for each procedure code. Medicare cross-over and state-only paid claims were excluded from the data.

3. FY 2012-13 data includes the 1% payment reduction to physicians, that was implemented pursuant to AB 1183 (Chapter 758, Statutes of 2008), effective March 1, 2009.

4. For FY 2014-15, the 2014 Medicare Physician Fee Schedule was used to determine California's weighted average Medicare rate for each procedure code.

5. Effective January 1, 2014, the ACA provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138% of the federal poverty level (FPL). Assume all ACA expansion population will transition into Medi-Cal managed care.

6. Based on the rate analysis, Medi-Cal payments to physicians for the selected procedure codes totaled $238,114,000 in FY 2012-13. Medi-Cal payments were determined to be at 48% of Medicare.

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

(Dollars in Thousands)

	Annual FFP
FFS	$259,822
Managed Care	$1,329,072
Total	$1,588,894

8. Administrative costs for managed care plans to implement the increase payments are estimated to be $78,125,000 TF annually. Regular managed care administrative costs and ACA Mandatory managed care administrative costs are funded at the regular 50% Federal Medical Assistance Percentage (FMAP). ACA Optional managed care administrative costs are funded at 100% FFP.

9. Some portion of the managed care capitation rates currently in place that were paid at 50% FMAP are eligible for 100% FMAP. The estimated total General Fund (GF) reimbursement due to the adjustment is $47,266,000. $35,450,000 was adjusted in FY 2013-14. The remaining balance, $11,817,000, will be adjusted in FY 2014-15.

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 21

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

(Dollars in Thousands)

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

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

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
FFS	$129,911	$0	$129,911
FFS Retro	$99,127	$0	$99,127
Managed Care (including Retro)	$409,585	$0	$409,585
ACA Mandatory	$80,506	$0	$80,506
ACA Optional	$174,445	$0	$174,445
Managed Care GF Reimbursement	$0	($11,817)	$11,817
Total Increase Payment	$893,574	($11,817)	$905,391
Managed Care Admin. Costs			
Regular	$24,884	$12,442	$12,442
ACA Mandatory	$4,478	$2,239	$2,239
ACA Optional	$9,701	$0	$9,701
Total Admin. Costs	$39,063	$14,681	$24,382
FFS (AB97 Savings Lost)	$23,076	$11,538	$11,538
Managed Care (AB97 Savings Lost)	$22,674	$11,337	$11,337
Total AB 97 Savings Lost	$45,750	$22,875	$22,875
Total	**$978,387**	**$25,739**	**$952,648**

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

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1821

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$499,157,000	$689,780,000
- STATE FUNDS	$90,620,600	$125,227,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$499,157,000	$689,780,000
STATE FUNDS	$90,620,600	$125,227,750
FEDERAL FUNDS	$408,536,400	$564,552,250

DESCRIPTION

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

Authority:
Title 42, CFR, Section 435.1110
Social Security Act 1902(a)(47)
SB 28 (Chapter 442, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change from Prior Estimate:
The Department revised caseload projections based on actual data through August. Actual enrollment is slightly higher than previously estimated in May. Additionally, per-member per-month (PMPM) costs were updated using actual fee-for-service (FFS) expenditures through August 2014. Compared to May, the updated PMPM costs increased significantly. In May the PMPM was a weighted average FFS PMPM which assumed a blend of all service categories. The updated PMPM is weighted more towards inpatient hospital services and physician services, which are higher cost service categories.

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 22

Methodology:

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

2. Based on actual certified eligible data through August 2014, it is estimated 36,024 average monthly eligibles will receive Hospital PE in FY 2014-15 and 34,307 in FY 2015-16.

3. Based on actual expenditure data through August 2014, it is estimated the weighted average PMPM costs are $1,154.67 (lagged) in FY 2014-15 and $1,675.51 in FY 2015-16.

4. The Department assumes many of the childless adults and parent/caretaker relatives will continue coverage beyond the presumptive eligibility period and be part of the ACA optional expansion. For those who enter as part of the optional expansion, the Department assumes retroactive ACA enhanced FFP will be available.

5. Total estimated benefit costs in FY 2014-15 and FY 2015-16 are:

FY 2014-15	TF	GF	FF
Pregnant Women	$1,167,000	$583,000	$584,000
Children Title XIX	$20,401,000	$10,201,000	$10,200,000
Children Title XXI	$1,386,000	$485,000	$901,000
Parents Title XIX	$12,663,000	$6,332,000	$6,331,000
Parents ACA FMAP	$25,709,000	$0	$25,709,000
Adults Title XIX	$143,718,000	$71,859,000	$71,859,000
Adults ACA FMAP	$291,791,000	$0	$291,791,000
Former Foster Care	$2,322,000	$1,161,000	$1,161,000
Total	**$499,157,000**	**$90,621,000**	**$408,536,000**

FY 2015-16	TF	GF	FF
Pregnant Women	$1,613,000	$806,000	$807,000
Children Title XIX	$28,192,000	$14,096,000	$14,096,000
Children Title XXI	$1,915,000	$670,000	$1,245,000
Parents Title XIX	$17,499,000	$8,750,000	$8,749,000
Parents ACA FMAP	$35,527,000	$0	$35,527,000
Adults Title XIX	$198,602,000	$99,301,000	$99,301,000
Adults ACA FMAP	$403,223,000	$0	$403,223,000
Former Foster Care	$3,209,000	$1,605,000	$1,604,000
Total	**$689,780,000**	**$125,228,000**	**$564,552,000**

ACA HOSPITAL PRESUMPTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 22

Funding:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$180,271	$90,136	$90,135
65% Title XIX / 35% GF (4260-113-0890/0001)	$1,386	$485	$901
100% Title XIX Federal Share (4260-101-0890)	$317,500	$0	$317,500
Total	**$499,157**	**$90,621**	**$408,536**

FY 2015-16	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$249,115	$124,558	$124,558
65% Title XIX / 35% GF (4260-113-0890/0001)	$1,915	$670	$1,245
100% Title XIX Federal Share (4260-101-0890)	$438,750	$0	$438,750
Total	**$689,780**	**$125,228**	**$564,552**

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	12/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1595

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$248,108,000	$225,260,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$248,108,000	$225,260,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$248,108,000	$225,260,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

The SPA was approved on August 31, 2012 with an effective date of December 1, 2011.

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

Reason for Change from Prior Estimate:
Estimated FY 2014-15 figures increased based on data provided by CDSS.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 23

Methodology:

1. It is assumed all eligible participants will enroll retroactively to December 1, 2011.

2. Assume billing for additional FFP will be retroactive to December 2011.

3. Assume costs will be retroactive to December 1, 2011.

4. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage (FMAP) rate of 6%.

5. The estimated costs were provided by CDSS on a cash basis.

Funding:

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

ACA DELAY OF REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1822

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$203,389,000	$43,470,000
- STATE FUNDS	$81,537,950	$17,836,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$203,389,000	$43,470,000
STATE FUNDS	$81,537,950	$17,836,300
FEDERAL FUNDS	$121,851,050	$25,633,700

DESCRIPTION

Purpose:
This policy change estimates the costs of delaying redeterminations and implementing the temporary modified renewal process for select currently enrolled Affordable Care Act (ACA) beneficiaries subject to the new modified adjusted gross income (MAGI) standards and several Non-MAGI groups.

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

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and mandatory expansions.

Effective January 1, 2014, the Department postponed annual redeterminations for 6-months for Medi-Cal beneficiaries who will be subject to the new MAGI standard and several non-MAGI groups. This 6-month delay helped provide counties with additional time to process the new incoming ACA expansion beneficiaries.

Effective July 1, 2014, the Department implemented a temporary modified renewal process for 6-months for Medi-Cal beneficiaries also subject to the new MAGI standard and several non-MAGI groups. The modified renewal process will only negatively impact those beneficiaries who do not

ACA DELAY OF REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER: 24

complete the required renewal forms. If the beneficiary completes the renewal process, regardless of eligibility status, the beneficiary will retain coverage until their next scheduled renewal.

Reason for Change from Prior Estimate:
In May, long-term care beneficiaries were included in the delayed Non-MAGI populations. In November, they have been removed from the Non-MAGI populations since they were exempt from the renewal delays. Additionally, costs related to the temporary modified renewal process have been added to this policy change.

Methodology:

1. Effective January 1, 2014, the Department delayed redeterminations until July 1, 2014 for current Medi-Cal beneficiaries. The Department assumes all delayed redeterminations will be completed no later than December 31, 2014.

2. Effective July 1, 2014, the Department implemented a modified renewal process until December 31, 2014 for select Medi-Cal populations:
   - Medically Needy,
   - Medically Indigent,
   - Undocumented Persons,
   - 250% Poverty,
   - 133% Poverty,
   - 100% Poverty, and
   - Former Low Income Health Program (LIHP).

3. The Department estimates during the delay in redeterminations Medi-Cal enrollment will increase by 150,586 additional member months for the MAGI population and 707,967 for the Non-MAGI population.

4. The average PMPM during this period for the MAGI population is $198.10, and $163.16 for the Non-MAGI population.

5. Total estimated (unlagged) costs related to the delay in redeterminations is:
   - MAGI: 150,586 additional member months x $198.10 PMPM = $29,831,000 TF (unlagged)
   - Non-MAGI: 707,967 member months x $163.16 PMPM = $115,512,000 TF (unlagged)
   - Total: $29,831,000 + $115,512,000 = $145,343,000 TF (unlagged)

6. Because of the weighted fee-for-service (FFS) payment lag between the service date and when a FFS claim is paid, the impact of the delay is realized in both FY 2013-14 and FY 2014-15:
   - FY 2013-14: $145,343,000 TF x .75878 weighted FFS payment lag = $110,284,000 TF
   - FY 2014-15: $145,343,000 - $110,284,000 = **$35,059,000** TF

7. The Department estimates during the modified renewal period Medi-Cal enrollment will increase by 510,096 additional member months in FY 2014-15 and 82,274 in FY 2015-16.

8. The weighted average PMPM during the modified renewal period is $356.06 in FY 2014-15 and $371.47 in FY 2015-16. This weighted average PMPM is based on a mix of Medically Needy, Medically Indigent, Undocumented, 250% Poverty, 133% Poverty, 100% Poverty and former LIHP. The higher PMPM is due to the inclusion of several higher cost populations.

ACA DELAY OF REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER: 24

9. Total estimated (unlagged) costs related to the modified renewal period is:
   - FY 2014-15: 510,096 additional member months x $356.06 PMPM = $181,623,000 TF
   - FY 2015-16: 82,274 additional member months x $371.47 PMPM = $30,562,000 TF

10. Because of the weighted FFS payment lag between the service date and when a FFS claim is paid, the estimated impact in FY 2014-15 and FY 2015-16 is:

    - FY 2014-15: $181,623,000 TF x .9268 weighted FFS payment lag = **$168,330,000** TF

    - FY 2015-16: $30,562,000 TF x .9874 weighted FFS payment lag = $30,177,000 TF
    - FY 2015-16: $30,177,000 TF + ($181,623,000 TF - $168,330,000 TF) = **$43,470,000 TF**

11. Total estimated FY 2014-15 and FY 2015-16 costs:

FY 2014-15	**TF**	**GF**	**FFP**
Delay of Redeterminations	$35,059	$16,776	$18,283
Modified Renewal Process	$168,330	$64,762	$103,568
Total	**$203,389**	**$81,538**	**$121,851**

FY 2015-16	**TF**	**GF**	**FFP**
Delay of Redeterminations	$0	$0	$0
Modified Renewal Process	$43,370	$17,836	$25,634
Total	**$43,370**	**$17,836**	**$25,634**

Funding:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$147,916	$73,958	$73,958
65% Title XXI FFP / 35% GF (4260-113-0890/0001)	$21,657	$7,580	$14,077
100% Title XIX ACA FFP (4260-113-0890)	$33,816	$0	$33,816
Total	**$203,389**	**$81,538**	**$121,851**

FY 2015-16	**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF (4260-101-0890/0001)	$30,151	$15,076	$15,076
65% Title XXI FFP / 35% GF (4260-113-0890/0001)	$7,888	$2,761	$5,127
100% Title XIX ACA FFP (4260-113-0890)	$5,431	$0	$5,431
Total	**$43,470**	**$17,836**	**$25,634**

ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1793

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$134,679,000	$95,588,000
- STATE FUNDS	$48,827,000	$34,655,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$134,679,000	$95,588,000
STATE FUNDS	$48,827,000	$34,655,000
FEDERAL FUNDS	$85,852,000	$60,933,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Effective January 1, 2014, the Affordable Care Act (ACA) expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA optional expansion.

Additionally, the ACA established online health insurance exchanges. Covered California, California's online health insurance exchange provides competitive health care coverage for individuals and small employers. As required by ACA, Covered California determines an applicant's eligibility for subsidized coverage. Individuals with incomes below 400% FPL will be eligible for federal subsidies to help offset the monthly premium costs. Covered California is available for citizens and legal residents to purchase health coverage.

ACA EXPANSION-NEW QUALIFIED IMMIGRANTS

REGULAR POLICY CHANGE NUMBER: 25

This policy change estimates the benefit costs for newly eligible NQI adult populations beginning January 1, 2014. Beginning January 1, 2016, the Department will begin transitioning new NQI eligibles and the optional expansion childless adult NQIs from Medi-Cal into Covered California. The Department will cover all out-of-pocket expenditures that may occur by transitioning into Covered California. The cost avoidance impact for the State is reflected in the summary table below.

Reason for Change from Prior Estimate:
The Department delayed the transition of NQI eligibles to Covered California beginning January 1, 2016. Additionally, the Medi-Cal per-member-per-month (PMPM) costs were updated.

Methodology:

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

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

3. Effective January 1, 2016, all childless adult NQIs will begin transitioning into Covered California. The Department will cover all premiums, copayments, and any differences in benefits that may occur from transitioning into Covered California.

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

(Dollars in Thousands)

Exchange related Costs:	**FY 2014-15**		**FY 2015-16**	
Newly Eligible NQI Childless Adults:	**TF**	**GF**	**TF**	**GF**
Premiums for 0-138%	$0	$0	$2,539	$921
Wraparounds 0-138%	$0	$0	$1,241	$450
Copays 0-138%	$0	$0	$4,245	$1,539
Subtotal	$0	$0	$8,025	$2,909
Medi-Cal related Costs:				
NQI Parents 101-138%:	$20,182	$7,317	$22,816	$8,272
Childless NQI Adults 0-138%:	$114,497	$41,510	$64,747	$23,474
Subtotal	$134,679	$48,827	$87,563	$31,746
Total DHCS Costs:	**$134,679**	**$48,827**	**$95,588**	**$34,655**
Medi-Cal related cost avoidance:				
Benefit cost avoidance 0-138%	$0	$0	($64,690)	($23,453)
Net Difference:	$134,679	$48,827	$30,898	$11,202

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

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	4/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1831

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$125,518,000	$80,353,000
- STATE FUNDS	$56,483,000	$36,159,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$125,518,000	$80,353,000
STATE FUNDS	$56,483,000	$36,159,000
FEDERAL FUNDS	$69,035,000	$44,194,000

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases to fund the federally required Health Insurer Fee.

Authority:
Affordable Care Act (ACA)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective January 1, 2014, the ACA places an $8 billion fee on the health insurance industry nationwide. The fee grows to $14.3 billion in 2018 and is trended based on the rate of premium growth after 2018. The fee will be allocated to qualifying health insurers based on their market share of premium revenue in the previous year. Market share is based on commercial, Medicare, Medicaid, and State Children Health Insurance Plan (SCHIP) premium revenues. Nonprofit insurers that receive more than 80% of their premium from non-commercial business (Medicare, Medicaid and SCHIP) are exempt from the fee. The fee is not exempt from corporate income tax, therefore the cost to the plans will be compounded by the tax that must be assessed to the revenue from the additional premium to the managed care plans to account for the Health Insurer Fee.

Reason for Change from Prior Estimate:
Due to the delay in collection of fees, payments will be shifted for FY 2014-15 and FY 2015-16.

Methodology:
1. It is estimated that the increase in premiums to Medi-Cal managed care over a five-year period will be approximately $536 million TF, including the cost of the fee and the cost of the associated corporate income tax on that revenue.

HEALTH INSURER FEE

REGULAR POLICY CHANGE NUMBER: 26

2. This fee will apply to Medi-Cal premiums for existing Medi-Cal beneficiaries (currently funded at 50% FMAP) and the expansion population, which will be funded at 100% FMAP. Therefore, this estimate assumes an overall FMAP of 55%.

3. Effective January 1, 2014, fees will be assessed to the plans by the federal government and will be ongoing thereafter. It is estimated that all payments for FY 2013-14 and FY 2014-15 will be made in late FY 2014-15. Payments for FY 2015-16 will be made in FY 2015-16.

4. Assume the following amounts:

(Dollars in Thousands)	FY 2014-15	FY 2015-16
FY 2013-14 Payments	$41,795	$0
FY 2014-15 Payments	$87,453	$0
FY 2015-16 Payments	$0	$87,453
	$129,248	$87,453
Included in the Dental FI Estimate	($3,730)	($7,100)
Total	**$125,518**	**$80,353**

5. The Internal Revenue Service will determine the effective rate and amount of tax on each plan. The total tax will be assessed on the plan's net premium.

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

ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS

REGULAR POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1792

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$51,916,000	$51,916,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$51,916,000	$51,916,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$51,916,000	$51,916,000

DESCRIPTION

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

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) expands Medicaid coverage to previously ineligible persons, primarily single, childless adults, at or below 138 percent of the federal poverty level (FPL), ages 19 to 64. The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of the ACA optional expansion.

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

AB 396 authorizes the Department, counties, and the CDCR to claim FFP for acute inpatient hospital and inpatient psychiatric services provided to Medi-Cal eligible juvenile inmates, under the age of 21, in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county.

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

ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS

REGULAR POLICY CHANGE NUMBER: 27

Reason for Change from Prior Estimate:
Updated costs based on actual utilization claims. In the May estimate, the cost per event was estimated at $12,111 and now based on actuals is estimated at $9,268.

Methodology:

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

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

3. Based on utilization claims information, the average cost for an adult inpatient admission is $9,268 for both State and county inmates.

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

5. Estimated Medi-Cal inpatient hospital costs for adult ACA inmates in FY 2014-15 and FY 2015-16 are:

FY 2014-15							**TF**	**FF**
State inmates	230	x	12	x	$9,268	=	$25,580,000	$25,580,000
County inmates	237	x	12	x	$9,268	=	$26,336,000	$26,336,000
Total	**467**						**$51,916,000**	**$51,916,000**

FY 2015-16							**TF**	**FF**
State inmates	230	x	12	x	$9,268	=	$25,580,000	$25,580,000
County inmates	237	x	12	x	$9,268	=	$26,336,000	$26,336,000
Total	**467**						**$51,916,000**	**$51,916,000**

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

USPSTF GRADE A AND B RECOMMENDATIONS

REGULAR POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1812

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$9,934,000	$11,760,000
- STATE FUNDS	$4,967,000	$5,880,000
PAYMENT LAG	0.9830	0.8730
% REFLECTED IN BASE	74.96 %	95.43 %
APPLIED TO BASE		
TOTAL FUNDS	$2,445,200	$469,200
STATE FUNDS	$1,222,590	$234,590
FEDERAL FUNDS	$1,222,590	$234,590

DESCRIPTION

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

Authority:
Affordable Care Act Section 4106

Interdependent Policy Changes:
PC 29 1% FMAP Increase for Preventative Services

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

The Department received approval of State Plan Amendment (SPA 13-014) to receive the additional 1% in FMAP, requiring the state to provide these services. The Department will ensure that they have appropriate codes or modifiers available for providers to utilize a crosswalk from those codes and modifiers to the USPSTF recommendations. To comply with the most recent recommendations, the Department added alcohol misuse screening and counseling services in primary care settings to the existing benefit package for beneficiaries 18 years and older.

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

- Updated eligibles caseload
- Updated Fee-for-Service (FFS) screening and intervention costs
- Managed care impact for preventative services is now budgeted in the managed care related policy changes

USPSTF GRADE A AND B RECOMMENDATIONS

REGULAR POLICY CHANGE NUMBER: 28

Methodology:

1. This new service was implemented on January 1, 2014.

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

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

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

5. Fee-for-Service (FFS) :
   - Assume estimated annual caseload growth is 1%.
   - For FY 2014-15, assume the estimated screening cost is $25.20 and $100.80 for intervention with 5% inflation factor.
   - For FY 2015-16, assume the estimated screening cost is $26.46 and $105.84 for intervention with 5% inflation factor.

6. Managed Care costs for preventative services are included in the managed care capitated rates.

7. Assume services provided to eligible beneficiaries under current Medi-Cal is paid at regular FMAP 50%. See the 1% FMAP Increase for Preventive Services policy change for the enhanced 1% FMAP savings.

FY 2014-15	TF	GF	FFP
Screening Costs	$6,072,000	$3,036,000	$3,036,000
Intervention Costs	$3,862,000	$1,931,000	$1,931,000
Total	**$9,934,000**	**$4,967,000**	**$4,967,000**

FY 2015-16	TF	GF	FFP
Screening Costs	$7,188,000	$3,594,000	$3,594,000
Intervention Costs	$4,572,000	$2,286,000	$2,286,000
Total	**$11,760,000**	**$5,880,000**	**$5,880,000**

Funding:

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

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	1/2015
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1791

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$85,513,000	-$45,544,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$85,513,000	-$45,544,000
FEDERAL FUNDS	$85,513,000	$45,544,000

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 28 USPSTF Grade A and B Recommendations

Background:
Effective January 1, 2013, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% in FMAP for providing specified preventive services. Eligible preventive services are those assigned grade A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). For states to be eligible to receive the enhanced FMAP, they must cover the specified preventive services in their standard Medicaid benefit package and cannot impose copayments for these services.

The Department will incorporate new recommended Grade A and B preventative services to the existing Medi-Cal benefit package. AB 82 prohibits copayments for preventative services. The Department will report state expenditures eligible for the additional 1% FMAP on the revised CMS 64.

Reason for Change from Prior Estimate:
- Updated caseloads
- Due to delay in obtaining CMS' approval of the 1% reimbursement methodology, GF savings from FY 2013-14 will shift to FY 2014-15.

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

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 29

2. Retroactive savings for period January 1, 2013 to June 30, 2014 will occur in FY 2014-15.

(Dollars In Thousands)

FY 2014-15	**TF**	**GF**	**FFP**
FFS	$0	($5,099)	$5,099
Managed Care	$0	($34,483)	$34,483
Retroactive Savings	$0	($45,931)	$45,931
Total	**$0**	**($85,513)**	**$85,513**

FY 2015-16	**TF**	**GF**	**FFP**
FFS	$0	($5,118)	$5,118
Managed Care	$0	($40,426)	$40,426
Total	**$0**	**($45,544)**	**$45,544**

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

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	10/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1802

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$230,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$230,000	$0
FEDERAL FUNDS	-$230,000	$0

DESCRIPTION

Purpose:
This policy change estimates a technical adjustment in funding from Title XIX 50/50 FMAP to 100% State GF for expenditures related to extending Medi-Cal coverage to former foster care youth who turned 21 years old between July 1, 2013 and December 31, 2013.

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). Additionally, the ACA requires the expansion of Foster Care Medicaid coverage to age 26, beginning January 1, 2014.

Effective July 1, 2013, the Department changed the age-out policy for former foster youth currently receiving Medi-Cal benefits. Prior to July 1, 2013, once a former foster youth turned 21 years old they would lose their Medi-Cal coverage. Instead under the new policy, those who turned 21 years old between July 1, 2013 and December 31, 2013 retained their Medi-Cal benefits. These costs are funded with 100% State General Fund.

Reason for Change from Prior Estimate:
The repayment of ineligible FFP will occur in FY 2014-15.

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

STATE-ONLY FORMER FOSTER CARE PROGRAM

REGULAR POLICY CHANGE NUMBER: 30

2. The Department estimates 549 former foster youth turned 21 years old between July 1, 2013 and December 31, 2013.

3. The total expenditures incurred for these eligibles are estimated to be $230,000.

4. The Department will repay CMS the ineligible FFP in FY 2014-15.

	FY 2014-15
General Fund	**$230,000**
FFP	**($230,000)**

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

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	1/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1845

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$17,742,000	-$36,129,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	18.60 %	54.90 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$14,441,990	-$16,294,180
FEDERAL FUNDS	$14,441,990	$16,294,180

DESCRIPTION

Purpose:
This policy change estimates the savings from receiving enhanced Title XIX FFP instead of the standard Title XIX FFP for newly eligible Medi-Cal beneficiaries who would have qualified under old Medi-Cal rules and subject to the standard Title XIX FFP.

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

Interdependent Policy Changes:
Not applicable

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. Currently eligible but not enrolled beneficiaries who enroll in Medi-Cal as result of enrollment simplification efforts are considered part of the ACA mandatory expansion. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as a result of both the ACA optional and mandatory expansions.

Beginning in 2014, the ACA establishes an enhanced FMAP for expenditures related to the optional expansion population. Between 2014 and 2016, the federal government will be responsible for 100 percent of the optional expansion expenditures, gradually phasing down to 90 percent in 2020 and beyond.

The Department estimates select populations will naturally shift into the optional expansion at the time of enrollment, and this policy change estimates the savings related to the difference of receiving the standard Title XIX 50/50 FMAP and the enhanced ACA FMAP.

ACA MAGI SAVINGS

REGULAR POLICY CHANGE NUMBER: 31

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

Methodology:

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

2. The Department estimates six select populations who were eligible prior to the ACA, that will take-up coverage as part of the ACA expansion group. They are:
   - Individuals who forego applying for disability determination because they are determined eligible for the new adult group;
   - Disabled individuals not enrolled in Medicare but need LTSS;
   - Medically needy 19 and 20 year olds without a share of cost not applying for Sneede v. Kizer;
   - Medically needy parents with a share of cost;
   - Pregnant women with incomes between 109 and 138% FPL;
   - SB 87 pending disability individuals.

3. The Department assumes for each select population only a proportion of the new enrollment beginning January 1, 2014 and thereafter, will elect to shift into the enhanced ACA group.

4. The total estimated savings in FY 2014-15 and FY 2015-16 are:

(Dollars in Thousands)	TF	FF	GF Savings
FY 2014-15	**$0**	**$17,742**	**($17,742)**
FY 2015-16	**$0**	**$36,129**	**($36,129)**

Funding:
100% State GF (4260-101-0001)
100% Title XIX Federal Share (4260-101-0890)

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	7/2015
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1742

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	-$3,000
- STATE FUNDS	$0	-$1,500
PAYMENT LAG	1.0000	0.9628
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$2,900
STATE FUNDS	$0	-$1,440
FEDERAL FUNDS	$0	-$1,440

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

The four provider types identified for RAC audits are Optometrists, Podiatrists, Non-emergency medical transportation and Speech Therapists. The combined billing for these providers for the past three years is $12,506,375. HMS estimates 1% is recoverable from their automated system. The policy change OA 31 Recovery Audit Contractor Costs will not be included in this estimate because HMS did not find any significant savings.

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

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 32

Methodology:

1. Assume the annual identified overpayment billing is $500,000.

   $500,000 x 1% recovery rate = $5,000 annual savings (rounded)

2. Savings will be phased in over 12 months beginning July 2015. Until the phase in is complete, assume $35 in monthly savings starting July 2015 and an additional $35 each month thereafter.

   $5,000 annual savings ÷ 12 months ÷ 12 month phase-in = $35 monthly phase-in

	TF	GF	FF
FY 2014-15	**($0)**	**($0)**	**($0)**
FY 2015-16	**($3,000)**	**($1,500)**	**($1,500)**

Funding:

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

MANAGED CARE DRUG REBATES

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$396,000,000	-$415,800,000
- STATE FUNDS	-$162,000,000	-$170,100,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$396,000,000	-$415,800,000
STATE FUNDS	-$162,000,000	-$170,100,000
FEDERAL FUNDS	-$234,000,000	-$245,700,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
For FY 2014-15, $66,000,000 in MCO rebates are included in the Aged and Disputed Drug Rebate Policy Change (PC-59). There is also the addition of the ACA expansion population.

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

2. Assume the annual invoice amount for FY 2014-15 is $440,000,000, which includes $80,000,000 in rebates associated with the mandatory ACA expansion population.

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 34

3. For FY 2014-15, assume the overall collection rate will be 90% of invoiced amounts.

(Dollars in Thousands)		
FY 2014-15		
$360,000 x 90% (non-ACA)	=	$324,000
$ 80,000 x 90% (ACA)	=	$ 72,000
		$396,000

4. For FY 2015-16, assume the there is a 5% increase in rebates invoiced and an overall collection rate of 90% of invoiced amounts.

(Dollars in Thousands)		
FY 2015-16		
$378,000 x 90% (non-ACA)	=	$340,200
$ 84,000 x 90% (ACA)	=	$ 75,600
		$415,800

5. Estimated collections for FY 2014-15 and FY 2015-16:

(Dollars in Thousands)	
Total FY 2014-15	**$ 396,000**
Total FY 2015-16	**$ 415,800**

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	5/2013
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1476

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$263,397,000	$291,544,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$263,397,000	$291,544,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$263,397,000	$291,544,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
SPA 09-023A was approved on April 25, 2013, retroactive to October 1, 2009. It authorizes CDDS to claim federal financial participation (FFP) for the provision of certain services by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include: habilitation, respite care, personal care services, homemaker services, and home health aide services. The SPA was approved on April 25, 2013, with a retroactive effective date of October 1, 2009.

AB3 X 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. SPA 11-041 authorizes CDDS to claim reimbursement, effective October 1, 2011 for the eliminated services rendered in FY 2011-12 and forward, enabling persons with developmental disabilities access to these benefits.

A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011. However, under CMS guidance, it was determined an amendment to the 1915(i) SPA was not necessary, and the Department will instead seek to amend an existing interagency agreement with the California Department of Developmental Services to draw down FFP

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 35

for infant development services.

In June 2012, SPA 12-020 was submitted to CMS to allow participants to self-direct selected HCBS under the 1915(i) program retroactive to April 1, 2012.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2009 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional Federal Financial Participation (FFP) for FY 2014-15 and FY 2015-16.

Reason for Change from Prior Estimate:
The estimated amounts for FYs 2014-15 and 2015-16 have been revised to reflect updated data.

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

(Dollars in Thousands)

	Total Funds	CDDS GF	FFP	ARRA
FY 2014-15	$526,793	$263,397	**$263,397**	**$0**
FY 2015-16	$577,715	$286,171	**$288,858**	**$2,686**

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

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	9/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1855

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$190,000,000	$320,000,000
- STATE FUNDS	$89,000,000	$151,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$190,000,000	$320,000,000
STATE FUNDS	$89,000,000	$151,000,000
FEDERAL FUNDS	$101,000,000	$169,000,000

DESCRIPTION

Purpose:
This policy change estimates the costs for providing Behavioral Health Treatment services (BHT) under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) services for children under age 21 with autism spectrum disorder (ASD.)

Authority:
SB 870 (Chapter 40, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
SB 870 (Chapter 40, Statutes of 2014) added W&I Code, Section 14132.56 to direct the Department to implement BHT services to the extent it is required by the federal government to be covered by Medi-Cal for individuals less than 21 years of age. This program ensures that children with autism will receive treatment so they do not become life-long dependents on government support. Discussions with CMS suggest that the Department is required to implement BHT under the federal interpretation for EPSDT Services for children under age 21. Once implemented, the effective date of this new service will be July 1, 2014.

The Department is working with the Department of Development Services (DDS) and stakeholders on a plan to transition current Medi-Cal eligible regional center clients who are receiving services. These services will be covered by Medi-Cal upon federal approvals. The transition plan is expected to be finalized later in FY 2014-15. The transition is expected to occur in 2015-16.

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

Methodology:
1. Assume implementation date of September 15, 2014 for BHT services.

BEHAVIORAL HEALTH TREATMENT

REGULAR POLICY CHANGE NUMBER: 36

2. Assume provider participation will phase-in evenly over six months.

3. Total expenditure for FY 2014-15 is estimated to be **$190,000,000 (TF)**.

4. Total expenditure for FY 2015-16 is estimated to be **$320,000,000 (TF)**.

Funding:

(Dollars in Thousands)

FY 2014-15	**TF**	**FF**	**GF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$150,000	$75,000	$75,000
65% Title XXI / 35% GF (4260-113-0890/0001)	$40,000	$26,000	$14,000
Total	**$190,000**	**$101,000**	**$89,000**

FY 2015-16	**TF**	**FF**	**GF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$260,000	$130,000	$130,000
65% Title XXI / 35% GF (4260-113-0890/0001)	$60,000	$39,000	$21,000
Total	**$320,000**	**$169,000**	**$151,000**

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	7/2000
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	25

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$128,839,000	$130,839,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$128,839,000	$130,839,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$128,839,000	$130,839,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

Reason for Change from Prior Estimate:
The change is due to incorporating a different reimbursement methodology.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 37

Methodology:

1. The FY 2014-15 estimate is based on the average total reimbursement amounts of the preceding three fiscal years.
2. The FY 2015-16 estimate is based on the FY 2014-15 base plus the estimated reconciliation.
3. The estimated reconciliation for FY 2008-09, of $4,000,000, will be applied to FY 2014-15.
4. The estimated reconciliation for FY 2009-10, of $6,000,000 will be applied to FY 2015-16.
5. The estimate is based on the analysis of historical claims submitted by LEAs.

(Dollars In Thousands)

FY 2014-15	**TF**	**FF**
FY 2014-15 Interim Payments	$124,839	$124,839
FY 2008-09 Reconciliation	$4,000	$4,000
FY 2014-15 Total	**$128,839**	**$128,839**

FY 2015-16	**TF**	**FF**
FY 2015-16 Interim Payments	$124,839	$124,839
FY 2009-10 Reconciliation	$6,000	$6,000
FY 2015-16 Total	**$130,839**	**$130,839**

Funding:

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

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	28

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$40,464,000	$40,464,000
- STATE FUNDS	$20,232,000	$20,232,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$40,464,000	$40,464,000
STATE FUNDS	$20,232,000	$20,232,000
FEDERAL FUNDS	$20,232,000	$20,232,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The MSSP provides social and health care management and purchases supplemental services to assist persons aged 65 and older who are "at risk" of needing nursing facility placement but who wish to remain in the community. The program provides services under a federal 1915(c) home and community-based services (HCBS) waiver for up to 12,000 participants in 9,443 participant slots, at $4,285 per year per slot.

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) provides the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only. No sooner than April 1, 2014, the Department will mandatorily enroll dual eligibles and SPDs into managed care for their Medi-Cal benefits. Those benefits comprise long-term supports and services (LTSS) including facility-based long-term care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and MSSP. Under CCI, managed care capitation will include MSSP services. In the eight CCI demonstration counties, participating managed care health plans will contract with the MSSP sites in their service area to deliver MSSP waiver services to their eligible health plan members. Eligible plan member will be enrolled into the MSSP waiver, subject to the availability of a waiver slot.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 38

As CCI is implemented, MSSP will transition to a Medi-Cal managed care benefit in all CCI demonstration counties (Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, San Bernardino, and Riverside). The total MSSP reimbursement (both for fee-for-service (FFS) and managed care (MC)) is budgeted in this policy change.

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

Methodology:

(Dollars in Thousands)

	TF	Reimbursement from CDA	FFP
FY 2014-15	**$40,464**	$20,232	$20,232
FY 2015-16	**$40,464**	$20,232	$20,232

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

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	4/2013
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1775

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$34,020,000	$34,020,000
- STATE FUNDS	$17,010,000	$17,010,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$34,020,000	$34,020,000
STATE FUNDS	$17,010,000	$17,010,000
FEDERAL FUNDS	$17,010,000	$17,010,000

DESCRIPTION

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

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

Interdependent Policy Changes:
OA 2 CCS Case Management
PC 111 County Organized Health Systems (COHS)
PC 154 Extend Hospital QAF – Hospital Payments
PC 123 Extend Gross Premium Tax – Incr. Capitation Rates
PC 132 Extend Gross Premium Tax – Funding Adjustment
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
The BTR, approved by the Centers for Medicare and Medicaid Services effective November 1, 2010, allows the Department to develop and implement organized health care delivery models to serve the CCS Medi-Cal eligible population.

Effective April 1, 2013, the Health Plan of San Mateo (HPSM) an existing managed care organization, began operation as a demonstration project under the Department's 1115 Bridge to Reform Waiver model.

Administrative payments to HPSM are applied to CCS Case Management.

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 39

Reason for Change from Prior Estimate:
Cost of UCLA independent evaluation contract moved to a new Other Administrative policy change.

Methodology:

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

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

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

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

   Annual HPSM administrative costs:
   $3,477,000 x 70% = $2,434,000 TF (monthly $202,800 TF)

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

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

6. Assume the CCS Pilot program is budget neutral.

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

(Dollars in Thousands)

	TF	HPSM	COHS	CCS Case Management
FY 2014-15	$0	**$34,020**	($31,586)	($2,434)
FY 2015-16	$0	**$34,020**	($31,586)	($2,434)

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1228

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$21,367,000	$31,677,000
- STATE FUNDS	$2,280,000	$3,846,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,367,000	$31,677,000
STATE FUNDS	$2,280,000	$3,846,000
FEDERAL FUNDS	$19,087,000	$27,831,000

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 51 California Community Transitions Savings
PC 44 CCT Fund Transfer to CDSS and CDDS
PC 47 Quality of Life Surveys for CCT Participants

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

Participants are enrolled in the demonstration for a maximum of 365-days, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2014 through June 30, 2015 are 500 individuals and 550 individuals for July 1, 2015 through June 30, 2016.

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 40

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

Reason for Change from Prior Estimate:
Costs decreased based on updated actual and projected CCT enrollment.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $66,613. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of $14,214 annually; reimbursed at 75% MFP and 25% GF.

3. Assume pre-transitions that are unsuccessful for non-DD beneficiaries cost $1,930 annually in FY 2014-15 and $2,027 annually in FY 2015-16; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $46,949 annually in FY 2014-15 and $49,296 annually in FY 2015-16; reimbursed at 75% MFP and 25% GF.

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

6. Assume DD beneficiaries, upon transitioning into CCT, cost $74,295 in FY 2014-15 and $78,010 in FY 2015-16 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.

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

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

(Dollars in Thousands)

	FY 2014-15		FY 2015-16	
	TF	GF	TF	GF
Lagged savings	($15,647)	($7,824)	($21,481)	($10,741)
Lagged costs	**$21,367**	**$2,280**	**$31,677**	**$3,846**
Net	$5,720	($5,544)	$10,196	($6,895)

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

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	1/2015
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1832

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$6,590,000	$22,251,000
- STATE FUNDS	$3,046,000	$10,274,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,590,000	$22,251,000
STATE FUNDS	$3,046,000	$10,274,000
FEDERAL FUNDS	$3,544,000	$11,977,000

DESCRIPTION

Purpose:
The policy change estimates the cost of implementing strategies to increase utilization rates for children. This policy estimates the increase in outreach activities and dental utilization for children ages 0-3.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Based on recommendations from the federal Centers for Medicare and Medicaid Services (CMS) and pursuant to requirements of the Healthy Families Program transition, the Department has identified effective strategies which will have positive health outcomes while increasing utilization of services for children. Specifically, the Department will identify beneficiaries age 0-3 on their birth months that have not had a dental visit during the past 12 months and mail parents/legal guardians of these individuals a letter encouraging them to take their children to see a dental provider as well as educational information about the importance of early dental visits.

Reason for Change from Prior Estimate:
The implementation date changed from July 2014 to January 2015.

Methodology:
1. Assume the mailing campaign to beneficiaries aged 0-3 will begin in January 2015.

2. Assume the mailing campaign will result in an increase of 10% in annual utilization for children ages 0-3.

3. The 10% increase in the number of users would be 77,985.

DENTAL CHILDREN'S OUTREACH AGES 0-3

REGULAR POLICY CHANGE NUMBER: 41

4. The average cost per user aged 0-5 is $272.51.

   77,985 x $272.51 = $21,252,000

5. An estimated 20% will be Title XXI Healthy Families.

   $21,252,000 x 20% = $4,250,000

6. For administrative costs, assume that there will be a 910,085 increase in Adjudicated Claim Service Line's (ACSL) with a $0.9427 cost per ACSL. Assume that there are 522,371 eligibles that letters would be sent to with $0.23 per letter and $0.04 per print.

   910,085 x $0.9427 = $ 858,000 ACSL
   522,371 x $0.23 = $ 120,000 Postage/mailing
   522,371 x $0.04 = $ 21,000 Printing
   $ 999,000

7. The annualized impact based upon FY 2014-15 costs is:

   $21,252,000 increased benefits + $999,000 administrative cost = $22,251,000 Total

8. Assume reimbursement will be provided for the non-federal share of costs.

9. Based upon an assumed six month phase-in in FY 2014-15, the fiscal impact in FY 2014-15 and FY 2015-16 will be:

FY 2014-15		TF	GF	FF
Title XIX (50/50)		$4,959,000	$2,479,000	$2,480,000
Title XXI (65/35)		$1,240,000	$434,000	$806,000
Admin Title XIX (various)		$391,000	$133,000	$258,000
	Total	**$6,590,000**	**$3,046,000**	**$3,544,000**

FY 2015-16		TF	GF	FF
Title XIX (50/50)		$17,002,000	$8,501,000	$8,501,000
Title XXI (65/35)		$4,250,000	$1,488,000	$2,762,000
Admin Title XIX (various)		$999,000	$285,000	$714,000
	Total	**$22,251,000**	**$10,274,000**	**$11,977,000**

Funding:
100% Title XIX (4260-101-0890)
100% Title XXI (4260-113-0890)
Reimbursement GF (4260-610-0995)

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1811

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$25,007,000	$29,458,000
- STATE FUNDS	$10,555,000	$12,537,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	57.50 %	67.12 %
APPLIED TO BASE		
TOTAL FUNDS	$10,628,000	$9,685,800
STATE FUNDS	$4,485,880	$4,122,330
FEDERAL FUNDS	$6,142,100	$5,563,460

DESCRIPTION

Purpose:
This policy change estimates the reimbursement funds for the Voluntary Inpatient Detoxification service.

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

Interdependent Policy Changes:
Not Applicable

Background:
Voluntary Inpatient Detoxification is an inpatient hospital service included in the State Plan. This service is provided when determined medically necessary, and with the voluntary participation of the Medi-Cal beneficiary.

Welfare & Institutions Code, Section 14132.03 requires Medi-Cal to cover substance use disorder services that are included in the essential health benefits package that the State adopted pursuant to Health & Safety Code, Section 1367.005. Because the package includes additional services that are currently not covered, Medi-Cal extended coverage for this new Voluntary Inpatient Detoxification service, effective January 1, 2014.

This change affects existing Medi-Cal beneficiaries as well as the newly eligibles that are added as a result of the Affordable Care Act (ACA) mandatory and optional expansions. For existing Medi-Cal beneficiaries and ACA mandatory expansion eligibles, reimbursement will be 50% FFP and 50% GF. For ACA optional expansion eligibles, reimbursement will be 100% FFP.

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

Methodology:
1. The eligible caseload projections are based on the average monthly eligibles projected for the

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 42

current, mandatory, and optional population expected to utilize Voluntary Inpatient Detoxification services.

2. Assume the caseload projection for the regular population is 3,004 for FY 2014-15 and 3,082 for FY 2015-16.

3. Assume the caseload projection for the mandatory expansion population is 286 for FY 2014-15 and 310 for FY 2015-16.

4. Assume the caseload projection for the optional expansion population is 578 for FY 2014-15 and 592 for FY 2015-16.

5. Assume the Units of Service (UOS) is five days of service per patient.

6. The proposed rate for Voluntary Inpatient Detoxification services is $1,490 per day based on the 2012 average Medi-Cal Selective Provider Contracting Program rate.

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

FY 2014-15	Caseload	UOS	Rate	Total
Regular	3,004	5	$1,490	$22,380,000
Mandatory	286	5	$1,490	$2,130,000
Optional	578	5	$1,490	$4,309,000
				$28,819,000

FY 2015-16	Caseload	UOS	Rate	Total
Regular	3,082	5	$1,490	$22,957,000
Mandatory	310	5	$1,490	$2,307,000
Optional	592	5	$1,490	$4,407,000
				$29,671,000

8. The cost estimate for FY 2013-14 is $13,574,000.

9. 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 2014-15	FY 2015-16
FY 2013-14	$13,574,000	$3,393,000	$0
FY 2014-15	$28,819,000	$21,614,000	$7,205,000
FY 2015-16	$29,671,000	$0	$22,253,000
		$25,007,000	**$29,458,000**

VOLUNTARY INPATIENT DETOXIFICATION

REGULAR POLICY CHANGE NUMBER: 42

10. The estimate on a cash basis will be:

(Dollars In Thousands)

FY 2014-15	**TF**	**GF**	**FF**
FY 2013-14	$3,393	$1,364	$2,029
FY 2014-15	$21,614	$9,191	$12,423
	$25,007	**$10,555**	**$14,452**
FY 2015-16			
FY 2014-15	$7,205	$3,064	$4,141
FY 2015-16	$22,253	$9,474	$12,779
	$29,458	**$12,538**	**$16,920**

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

*Totals may differ due to rounding.

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1772

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$6,301,000	$6,589,000
- STATE FUNDS	$30,000	$36,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,301,000	$6,589,000
STATE FUNDS	$30,000	$36,000
FEDERAL FUNDS	$6,271,000	$6,553,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
The changes are due to updated daily rate.

Methodology:
1. The program was implemented in January 2014 with an effective date of September 1, 2013.

2. $776,000 FFP from last quarter of FY 2013-14 will be reimbursed in FY 2014-15.

3. Assume 50 youths will be enrolled in the program in FY 2014-15 and FY 2015-16.

4. Assume the average stay per youth is 180days.

5. Calendar year 2013 daily rate per youth is $684.

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 43

6. Assume the daily rate increases annually by $32.

FY 2014-15
(2014 calendar year rate of $684)
25 youths x 180 days per youth x $684 per day = $3,078,000 TF

(2015 calendar year rate of $716)
25 youths x 180 days per youth x $716 per day = $3,222,000 TF

FY 2015-16
(2015 calendar year rate of $716)
25 youths x 180 days per youth x $716 per day = $3,222,000 TF

(2016 calendar year rate of $748)
25 youths x 180 days per youth x $748 per day = $3,366,000 TF

7. Assume the program will pay the quarterly expenditures upfront at 50% FMAP, and receive FFP reimbursement in the following quarter.

(Amounts may differ due to rounding)

FY 2014-15	**TF**	**GF**	**FFP**
*Apr - Jun 2014	$0	($776,000)	$776,000
Jul - Dec 2014	$3,078,000	$0	$3,078,000
**Jan - Jun 2015	$3,223,000	$806,000	$2,417,000
	$6,301,000	**$30,000**	**$6,271,000**

FY 2015-16	**TF**	**GF**	**FFP**
*Apr - Jun 2015	$0	($806,000)	$806,000
Jul - Dec 2015	$3,222,000	$0	$3,222,000
**Jan - Jun 2016	$3,367,000	$842,000	$2,525,000
	$6,589,000	**$36,000**	**$6,553,000**

* FFP reimbursement from previous quarter
** FFP to be reimbursed in the following fiscal year

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

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	10/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1562

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$4,116,000	$4,330,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,116,000	$4,330,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,116,000	$4,330,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
Updated actual and projected CCT enrollment adjusted FY 2014-15 and FY 2015-16 costs as well as CDDS and CDSS reconciliation for the period of August 2012 through May 2014.

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

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 44

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

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

4. It is assumed that 64% of all non-DD enrollees utilize IHSS under CCT. Assume each case costs $29,012 in FY 2014-15 and $30,463 in FY 2015-16. The Department will provide 25% of these costs to CDSS.

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

6. Due to system problems with CMIPS II during the period of August 2012 through May 2014, it is anticipated that CDDS will receive an estimated $500,000 FFP, and CDSS will receive $700,000 from reconciled services costs. These costs are expected to be transferred to the appropriate department during FY 2014-15.

Estimated Costs:

	FY 2014-15	FY 2015-16
CDSS	$1,620,000	$1,701,000
CDDS	$1,296,000	$2,629,000
CDSS Reconciliation	$700,000	$0
CDDS Reconciliation	$500,000	$0
Total	**$4,116,000**	**$4,330,000**

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

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	7/2013
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1787

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$540,000	$760,000
- STATE FUNDS	$270,000	$380,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$540,000	$760,000
STATE FUNDS	$270,000	$380,000
FEDERAL FUNDS	$270,000	$380,000

DESCRIPTION

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

Authority:
AB 1745 (Chapter 330, Statutes of 2006)

Interdependent Policy Changes:
PC 202 Pediatric Palliative Care Expansion And Savings

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

Effective July 1, 2013, the Department reimbursed PPCW agencies for administrative costs. This policy change provides $300 per member per month (PMPM) to reimburse the PPCW agencies for indirect services, such as administrative support, overhead, and program training.

A waiver amendment is expected to be approved by CMS by February 1, 2015 which will cease payment of the $300 PMPM administrative fee and increase the provider reimbursement rates by the same amount. A rate study was completed to determine the increase in rate for each service category, totaling $300 PMPM.

Based upon an independent evaluation by the University of California, Los Angeles, Center for Health Policy Research, the PPCW pilot project was found to be cost-effective. A gross claims cost reduction of $3,133 PMPM was predominately driven by a major decrease in inpatient care costs. Associated administrative costs affect the reduction, but the project remains cost-effective.

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 45

Reason for Change:
There is no change.

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

1. Assume a total of 150 members enrolled in PPCW for FY 2014-15.

2. Assume caseload expanding to 270 members through FY 2015-16 by adding 17-18 members per month.

3. Assume a $300 per member per month cost for administrative costs paid as a fee for July 1, 2014 – January 31, 2015.

4. Assume a $300 per member per month cost for administrative costs paid via increased provider reimbursement rates effective February 1, 2015.

For FY 2014-15, 150 members x 12 months = 1,800 member months (MM)

1,800 MM x $300 PMPM = $540,000 TF

For FY 2015-16, the caseload expansion includes an additional 732 MM.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Member Months
17	17	34	34	51	51	68	68	85	85	102	120	**732**

732 MM x $300 PMPM = $220,000 (caseload expansion)

$540,000 + $220,000 = $760,000 TF

	TF	GF	FF
FY 2014-15	**$540,000**	**$270,000**	**$270,000**
FY 2015-16	**$760,000**	**$380,000**	**$380,000**

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	8/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1436

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$320,000	$411,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$320,000	$411,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$320,000	$411,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

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

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 46

Reason for Change from Prior Estimate:
Updated actual enrollment through July 2014.

Methodology:

1. The waiver has a maximum capacity of 486 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment began in August 2012. Target enrollment for the period of July 1, 2014 through June 30, 2015 has been revised to 25 individuals and 30 individuals for July 1, 2015 through June 30, 2016.

2. The enrollment will be phased in throughout the year. Total participant months in FY 2014-15 will be 248, and 312 in FY 2015-16.

3. The annual total cost is estimated to be $30,928 per participant in FYs 2014-15 and $31,620 in 2015-16.

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

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

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

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	7/2010
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1550

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$145,000	$155,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$145,000	$155,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$145,000	$155,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

Reason for Change from Prior Estimate:
Costs have increased due to actual data from FYs 2012-13 and 2013-14.

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 47

Methodology:

1. The QoL surveys began in July 2010.

2. In FY 2012-13, 454 beneficiaries were transitioned in the CCT demonstration project and 449 additional beneficiaries transitioned into CCT in FY 2013-14. Projected enrollments are 550 in FY 2014-15 and 550 in FY 2015-16.

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

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

550 x $100 = $55,000 Baseline
449 x $100 = $44,900 First follow up
454 x $100 = $45,400 Second follow up

FY 2014-15 Estimated Costs: **$145,000 TF** (rounded)

550 x $100 = $55,000 Baseline
550 x $100 = $55,000 First follow up
449 x $100 = $44,900 Second follow up

FY 2014-15 Estimated Costs: **$155,000 TF** (rounded)

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

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	7/2015
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1854

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$18,236,000
- STATE FUNDS	$0	$8,434,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$18,236,000
STATE FUNDS	$0	$8,434,300
FEDERAL FUNDS	$0	$9,801,700

DESCRIPTION

Purpose:
This policy change increases the number of screenings for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to align with the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule.

Authority:
State Plan Amendment (SPA) 13-014
Affordable Care Act (ACA) (P.L. 111-148) Section 2713(a)(3)
The Health Insurance Affordability and Accountability Act of 1986 (P.L. 104-191).

Interdependent Policy Changes:
Not Applicable

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

The CHDP legacy periodicity schedule provides for 15 periodic well child health assessments between birth and age 21. The AAP Bright Futures periodicity schedule provides for 29 periodic well child health assessments between birth and age 21. Implementation of the AAP Bright Futures periodicity schedule conforms Medi-Cal Fee For Service (FFS) EPSDT well child health assessments for children who are full scope Medi-Cal beneficiaries to the periodicity required by ACA Section 2713 (a)(3) and SPA 13-014.

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

Methodology:
The following assumptions were used to estimate the additional health assessments cost:

IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT

REGULAR POLICY CHANGE NUMBER: 48

1. Legacy periodicity base costs of $38,799,000 less 25% for lab, vaccine administration and billable tests.
   $38,799,000 – ($38,799,000 x 25%) = $29,100,000

2. Assume reduction for utilization and FFS caseload decline of 40% due to additional shifts to managed care.
   $29,100,000 – ($29,100,000 x 40%) = $17,460,000

3. Increase in periodicity from 15 lifetime screens to 29 lifetime screens.
   $17,460,000 / 15 screens = $1,164,000 per screen
   $1,164,000 x 14 additional screens = $16,296,000 for additional screens

4. Assume an increase (5% of base) for Bright Futures autism screen and lipid panel due to the autism assessment requirement in the Bright Futures periodicity schedule and increased autism awareness.
   $38,799,000 x 5% = $1,940,000

   FY 2015-16: $16,296,000 + $1,940,000 = $**18,236,000 TF ($8,434,000 GF)**

Funding:

(Dollars in Thousands)

FY 2015-16:

		TF	GF	FF
50% Title XIX / 50% GF	4260-101-0001/0890	$13,678	$6,839	$6,839
65% Title XXI / 35% GF	4260-113-0001/0890	$4,558	$1,595	$2,963
Total for FY 2015-16		**$18,236**	**$8,434**	**$9,802**

CHDP PROGRAM DENTAL REFERRAL

REGULAR POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	7/2015
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1870

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$808,000
- STATE FUNDS	$0	$404,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$808,000
STATE FUNDS	$0	$404,000
FEDERAL FUNDS	$0	$404,000

DESCRIPTION

Purpose:
This policy change estimates the cost of referring, Medi-Cal eligible, Child Health and Disability Prevention (CHDP) program children to a dentist at one year of age.

Authority:
Proposed Legislation

Interdependent Policy Changes:
Not Applicable

Background:
California Health and Safety Code Section 124040 requires the governing body of each county to establish a CHDP program. Subsection (a)(6)(D) requires that the health screening and evaluation portion of the CHDP program include ear, nose, mouth, and throat inspection, including inspection of teeth and gums, and for all children three years of age and older who are eligible for Medi-Cal, referral to a dentist participating in the Medi-Cal program.

The Department is preparing a FY 2015-16 legislative proposal that would amend the Health & Safety Code to require local CHDP programs and CHDP providers to refer all children participating in the program, who are at least one year of age and who are eligible for Medi-Cal, to a dentist participating in the Medi-Cal program, rather than at three years of age.

Reason for Change:
This is a new policy change.

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

1. Based on FY 2012-13 actual data, 4,549 (1.43%) of the 318,179 CHDP children one to two years of age that received dental assessments were referred to a dentist.

CHDP PROGRAM DENTAL REFERRAL

REGULAR POLICY CHANGE NUMBER: 49

2. Based on FY 2012-13 actual data, 8,275 (2.76%) of the 300,350 CHDP children age three to five were referred to a dentist.

3. Assume that, after legislation is amended, CHDP children one to two years of age will be referred at the same rate as those three to five years of age; 2.76%.

   318,179 x 2.76% = 8,782 referrals for CHDP children one to two years of age.

4. Currently, 4,549 CHDP children one to two years of age are already being referred.

   8,782 – 4,549 = 4,233 additional referrals for CHDP children one to two years of age.

5. The average cost of dental treatment for CHDP children one to two year of age in FY 2012-13 was $190.96. Assume the FY 2015-16 cost of dental treatment is the same; the following shows the costs for FY 2015-16.

   FY 2015-16: 4,233 x $190.96 = **$808,000 TF ($404,000 GF)**

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

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	11/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1770

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$8,922,000	-$14,958,000
- STATE FUNDS	-$1,735,200	-$3,096,600
PAYMENT LAG	0.9693	0.9955
% REFLECTED IN BASE	70.90 %	54.55 %
APPLIED TO BASE		
TOTAL FUNDS	-$2,516,600	-$6,767,800
STATE FUNDS	-$489,440	-$1,401,070
FEDERAL FUNDS	-$2,027,150	-$5,366,750

DESCRIPTION

Purpose:
This policy change estimates the cost and cost-avoidance from reproductive health services benefit changes to the Family Planning, Access, Care and Treatment (Family PACT) and Medi-Cal programs.

Authority:
Welfare & Institutions Code 14132(aa)(8)
Affordable Care Act, Section 2303(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
The Department conducts on-going monitoring and utilization management of reproductive health services to expand access to services, evaluate the cost-effectiveness of services, and identify opportunities to reduce program costs while maintaining the same quality of care.

The following changes were made to benefits related to women's health services:

For Family PACT and Medi-Cal Fee-for-Service, effective November 1, 2013, the Department:

- Decreased the onsite dispensing of emergency contraception from two packs per dispense to one
- Added onsite dispensing of the emergency contraceptive, ella®
- Increased the dispensing fee for Long Acting Reversible Contraception (LARC)

For Family PACT, effective November 1, 2013, the Department:

- Eliminated urine culture
- Discontinued brand name anti-fungal drugs

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 50

For Medi-Cal, effective November 1, 2013, the Department increased reimbursement rates for pregnancy termination services.

For Family PACT, effective January 1, 2014, the Department:

- Eliminated screening mammography benefits
- Eliminated two pregnancy test-only diagnosis codes

For Family PACT, effective April 1, 2014, the Department reduced chlamydia and gonorrhea screening of women over 25 years of age.

For Family PACT and Medi-Cal Fee-for Service, effective July 1, 2014, the Department increased the insertion fee for LARCs.

For Family PACT, effective January 1, 2015, the Department plans to adopt a Medi-Cal Preferred List for oral contraceptives.

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

- Updated claims data
- Implementation for Medi-Cal Preferred List of Oral Contraceptives was delayed from July 1, 2014 to January 1, 2015
- LARC Insertion Fee rate increase for Family PACT

Methodology:
1. The estimated savings below is based on FY 2012-13 data:

Benefit	FMAP*	FY 2014-15 TF	FY 2015-16 TF
Chlamydia Screening	90%	(6,327,000)	(6,327,000)
Gonorrhea Screening	90%	(6,223,000)	(6,223,000)
Emergency Contraception	90%	(7,228,000)	(7,228,000)
Clinical dispensing of ella®	90%	1,752,000	1,226,000
Medi-Cal List of Oral Contraceptives	90%	(2,000,000)	(4,000,000)
Mammograms	0%	(4,628,000)	(4,628,000)
Urine Culture	50%	(557,000)	(557,000)
Brand Name Antifungal Drug	50%	(600,000)	(600,000)
Pregnancy Test Only	90%	(311,000)	(311,000)
LARC Fee Increase	90%	6,000,000	4,200,000
LARC Insertion Fee	90%	5,700,000	3,990,000
Abortion Rate Increase	0%	5,500,000	5,500,000
Total Savings		**(8,922,000)**	**(14,958,000)**

WOMEN'S HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 50

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

FY 2014-15	TF	GF	FFP
90/10 Savings	($7,432,000)	($743,000)	($6,689,000)
50/50 Savings	($996,000)	($498,000)	($498,000)
100% GF Savings	($494,000)	($494,000)	$0

FY 2015-16	TF	GF	FFP
90/10 Savings	($12,626,000)	($1,263,000)	($11,364,000)
50/50 Savings	($996,000)	($498,000)	($498,000)
100% GF Savings	($1,336,000)	($1,336,000)	$0

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

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	12/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1222

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$15,647,000	-$21,481,000
- STATE FUNDS	-$7,823,500	-$10,740,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$15,647,000	-$21,481,000
STATE FUNDS	-$7,823,500	-$10,740,500
FEDERAL FUNDS	-$7,823,500	-$10,740,500

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 51 California Community Transitions Savings
PC 44 CCT Fund Transfer to CDSS and CDDS
PC 47 Quality of Life Surveys for CCT Participants

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

Participants are enrolled in the demonstration for a maximum of 365-days, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2014 through June 30, 2015 are 500 individuals and 550 individuals for July 1, 2015 through June 30, 2016.

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

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 51

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

Reason for Change from Prior Estimate:
The participant phase-in has been revised based on actual data.

Methodology:

1. Assume estimated costs of waiver impacted services for persons residing year-round in Nursing Facility (NF)-Bs would be $66,613. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of $14,214 annually; reimbursed at 75% MFP and 25% GF.

3. Assume pre-transitions that are unsuccessful for non-DD beneficiaries cost $1,930 annually in FY 2014-15 and $2,027 annually in FY 2015-16; reimbursed at 100% MFP.

4. Assume non-DD beneficiaries, upon transitioning into CCT, cost $46,949 annually in FY 2014-15 and $49,296 annually in FY 2015-16; reimbursed at 75% MFP and 25% GF.

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

6. Assume DD beneficiaries, upon transitioning into CCT, cost $74,295 in FY 2014-15 and $78,010 in FY 2015-16 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.

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

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

(Dollars in Thousands)

	FY 2014-15		FY 2015-16	
	TF	**GF**	**TF**	**GF**
Lagged savings	**($15,647)**	**($7,824)**	**($21,481)**	**($10,741)**
Lagged costs	$21,367	$2,280	$31,677	$3,846
Net	$5,720	($5,544)	$10,196	($6,895)

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

RESTORATION OF ENTERAL NUTRITION BENEFIT

REGULAR POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	5/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1801

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$28,892,000	$28,892,000
- STATE FUNDS	$14,446,000	$14,446,000
PAYMENT LAG	0.9952	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$28,753,300	$28,892,000
STATE FUNDS	$14,376,660	$14,446,000
FEDERAL FUNDS	$14,376,660	$14,446,000

DESCRIPTION

Purpose:
This policy change estimates the cost of expanding Medi-Cal coverage of enteral nutrition products (formula).

Authority:
Welfare & Institutions Code 14132.86
CCR, Title 22, Section 51313.3

Interdependent Policy Change:
Not Applicable

Background:
Enteral nutrition products may be covered upon authorization when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food.

AB 97 (Chapter 3, Statutes of 2011) limited enteral nutrition products (formula) to those products to be administered through a feeding tube. However, AB 97 exempts the beneficiaries under Early Periodic Screening, Diagnosis and Treatment (EPSDT) from the limit and allows the Department to deem an enteral nutrition product not administered through a feeding tube a benefit for patients with diagnoses including, but not limited to, malabsorption syndromes and inborn errors of metabolism.

AB 82 repeals the tube feeding restrictions on enteral nutrition products, which expanded coverage to include oral and tube-feeding use for beneficiaries that meet specific medical and product, effective May 1, 2014.

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

RESTORATION OF ENTERAL NUTRITION BENEFIT

REGULAR POLICY CHANGE NUMBER: 52

Methodology:

1. The restoration of enteral nutrition products administered orally for adults was implemented May 1, 2014 with utilization controls through the establishment of specific medical criteria.

2. Fee-for-service expenditures for enteral nutrition products were approximately $32,777,000 annually before the AB 97 change. The Department estimates utilization of enteral nutrition products in FY 2014-15 and FY 2015-16 to remain the same.

3. Of this amount, expenditures for tube-fed adults were approximately $3,885,000 annually.

4. The annual expenditures for the restoration of coverage for oral-fed adults are estimated to be:

   $32,777,000
   -$ 3,885,000
   $28,892,000 ($14,446,000 GF)

5. There is a FY 2014-15 payment lag of 0.9952.

   $28,892,000 x 0.9952 = $28,753,300

6. Total expenditures for adults:

(Dollars in Thousands)

	TF	GF	FF
Total FY 2014-15	**$ 28,753**	**$ 14,377**	**$ 14,376**
Total FY 2015-16	**$ 28,892**	**$ 14,446**	**$ 14,446**

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

PEDIATRIC MOBILE VISION PROJECT

REGULAR POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	1/2015
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1849

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,036,000	$4,072,000
- STATE FUNDS	$1,018,000	$2,036,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,036,000	$4,072,000
STATE FUNDS	$1,018,000	$2,036,000
FEDERAL FUNDS	$1,018,000	$2,036,000

DESCRIPTION

Purpose:
This policy change estimates the cost of a pilot program in Los Angeles County to provide vision care services at schools via a mobile vision care service provider.

Authority:
Senate Bill 870 (Budgets, Chapt 40, Statutes of 2014). Sections 4 and 11.

Interdependent Policy Changes:
Not Applicable

Background:
The Department will implement a 3-year pilot program to increase access to vision care services and eye glasses to children by allowing a mobile vision service provider that has an established Memorandum of Understanding with school districts within Los Angeles County to contract with the managed care health plans in Los Angeles County for the provision of these vision care services at school sites. Any capitation rate adjustment for the managed care plans will be actuarially based and developed using projections of contingent events, including targeted populations who will receive these services to account for the increased utilization.

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

Methodology:

1. Assume the pilot program in Los Angeles County will begin in January 2015.

2. Assume that there will be 45,000 children screened annually.

3. Assume that the average cost per child will be $90.48 for examinations and necessary lenses and frames.

PEDIATRIC MOBILE VISION PROJECT

REGULAR POLICY CHANGE NUMBER: 53

4. Annual expenditures for the anticipated increase in utilization of vision exams and eye glasses are estimated to be:

   45,000 children X $90.48 per child = $4,072,000 annual cost.

5. FY 2014-15 cost is estimated to be:

   $4,072,000 annual cost X 6 months/12 months = $2,036,000 ($1,018,000 GF).

6. FY 2015-16 cost is estimated to be:

   $4,072,000 annual cost = $4,072,000 ($2,036,000 GF).

7. These estimates are based upon fee-for-service costs while the actual rates will be actuarially-based.

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

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	3/2007
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	108

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$1,389,000	$1,550,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$1,389,000	$1,550,000
FEDERAL FUNDS	-$1,389,000	-$1,550,000

DESCRIPTION

Purpose:
This policy change budgets 100% General Fund (GF) costs to reimburse the federal share to the Centers for Medicare and Medicaid Services (CMS) for drugs ineligible for federal financial participation (Non-FFP drugs).

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

Interdependent Policy Changes
Not Applicable

Background:
Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid programs if the manufacturer of the drug has not signed a rebate contract with the CMS.

Effective March 2007, an automated quarterly report was made available to determine the costs of drugs for which there is no FFP. The Department reimburses the federal government for FFP claimed for these drugs.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from September 2013 to March 2014.

Methodology:
1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased. Based on data from July 2004 to March 2014, the FFP actual total costs were compared to the base estimate amounts which created a percentage used to calculate the estimate.

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 54

(Dollars in Thousands)

	Non-FFP Drug Expenditures	Est. FFP Repayment
FY 2014-15	$ 2,778	**$ 1,389**
FY 2015-16	$ 3,100	**$ 1,550**

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	1/2010
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1433

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$18,000,000	-$18,000,000
- STATE FUNDS	-$6,300,000	-$6,300,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$18,000,000	-$18,000,000
STATE FUNDS	-$6,300,000	-$6,300,000
FEDERAL FUNDS	-$11,700,000	-$11,700,000

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

Authority:
Welfare & Institutions Code 14105.33(b)(4)

Interdependent Policy Changes:
Not Applicable

Background:
Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP program in January 2010. This policy change reflects ongoing rebates invoiced. Revenues resulting from the resolution of disputed rebates are budgeted in the Aged and Disputed Drug Rebate policy change.

Reason for Change from Prior Estimate:
There is an increase in rebate collections for BCCTP based on actual data from FY 2013-14.

Methodology:
1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. It is estimated that $18,000,000 in rebates will be collected in both FY 2014-15 and FY 2015-16.

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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	10/2006
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1181

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$31,000,000	-$31,000,000
- STATE FUNDS	-$15,500,000	-$15,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$31,000,000	-$31,000,000
STATE FUNDS	-$15,500,000	-$15,500,000
FEDERAL FUNDS	-$15,500,000	-$15,500,000

DESCRIPTION

Purpose:
This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Authority:
Welfare & Institutions Code 14100.95(a) and 14105.47(c)(1)

Interdependent Policy Changes:
Not Applicable

Background:
The Department negotiates Maximum Acquisition Cost (MAC) for diabetic testing supplies with manufacturers to make available the best price to all providers. The Department establishes the product reimbursement rates for diabetic testing products which are based on the contracted MAC. The Department also negotiates rebates with some diabetic testing supply manufacturers to provide savings to the Department. The rebates are a percentage of the MAC per unit of services (quantity) reimbursed.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers for the contracted rebate percentage of the MAC.

Reason for Change from Prior Estimate:
Based on the analysis of FY 2013-14 data, there is an increase in utilization which led to an increase in the rebate collections.

Methodology:
1. The current medical supply diabetic testing products rebate contract terms were effective January 1, 2013.

2. Based on actual rebate data for the last four quarters, the average quarterly collection is $7,750,000.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 56

3. Based on the current contract terms, assume no significant change in rebate collected.

Annual Collections:

$7,750,000 x 4 qtrs. = **$ 31,000,000**

CASH BASIS	Medical Supply Rebates
FY 2014-15	**($ 31,000,000)**
FY 2015-16	**($ 31,000,000)**

Funding:

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

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	8/2009
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1449

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$40,959,000	$0
- STATE FUNDS	-$40,959,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$40,959,000	$0
STATE FUNDS	-$40,959,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to overcharges.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department works collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks and overcharging of Medicaid.

Reason for Change from Prior Estimate:
Additional settlement agreements were added.

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 57

Methodology:
The following settlements are expected to be received in FY 2014-15:

	FY 2014-15
Astellas	($696,541)
Banigan I	($2,382,998)
Banigan II	($2,655,060)
Bioscrip	($65,406)
Bioscrip	($371,000)
Bio Med	($2,000,000)
EBI (Biomet)	($3,792)
Endo Pharmaceuticals	($357)
ISTA Pharmaceuticals	($151,989)
Johnson and Johnson	($2,977,000)
Johnson & Johnson (Omnicare)	($1,848,000)
KV Pharmaceuticals, Inc.	($58,950)
Medtronic	($80,968)
Novatris	($4,000)
Omnicare	($725,373)
Pacific Health Corporation	($635,000)
Seacliff Diagnostics	($124,000)
Senior Care Action Network	($24,672,898)
Saint Helen's	($160,000)
Shire	($1,344,416)
Victory Pharma	($1,000)
Total GF Savings, Initial Settlement Amts	**($40,959,000)**

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	12/1999
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	51

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$66,036,000	-$66,036,000
- STATE FUNDS	-$8,283,600	-$8,283,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$66,036,000	-$66,036,000
STATE FUNDS	-$8,283,600	-$8,283,600
FEDERAL FUNDS	-$57,752,400	-$57,752,400

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

Authority:
Welfare & Institutions Code 14105.33 (b)(4)

Interdependent Policy Changes:
Not Applicable

Background:
Rebates for drugs covered through the FPACT program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from January 2014 to June 2014.

Methodology:
1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 6.36% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 93.64% of the FPACT rebates.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 58

2. We use actual data from January 2012 to June 2014 to project rebates.

CASH BASIS
(Dollars in Thousands)

Fiscal Year	FPACT Drug Expenditures	FPACT Rebate
FY 2014-15	$132,670	**($66,036)**
FY 2015-16	$132,670	**($66,036)**

FY 2014-15

	TF	GF	FF
Title XIX 50/50	($4,200)	($2,100)	($2,100)
Title XIX 90/10	($61,836)	($6,184)	($55,652)
Total	**($66,036)**	**($8,284)**	**($57,752)**

FY 2015-16

	TF	GF	FF
Title XIX 50/50	($4,200)	($2,100)	($2,100)
Title XIX 90/10	($61,836)	($6,184)	($55,652)
Total	**($66,036)**	**($8,284)**	**($57,752)**

Funding:
50% Title XIX /50% GF (4260-101-0001/0890)
90% Title XIX /10% GF (4260-101-0001/0890)

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	1/1991
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	54

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$157,745,000	-$173,570,000
- STATE FUNDS	-$65,819,600	-$72,407,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$157,745,000	-$173,570,000
STATE FUNDS	-$65,819,600	-$72,407,800
FEDERAL FUNDS	-$91,925,400	-$101,162,200

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

Authority:
Welfare & Institutions Code 14105.33

Interdependent Policy Changes:
Not Applicable

Background:
State supplemental drug rebates for drugs provided through fee-for-service (FFS) and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from January 2014 to June 2014.

Methodology:
1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. In the past three years, the average percentage of collections in State supplemental rebates was 6.26% of actual drug expenditures.

3. In FY 2014-15 and FY 2015-16, it is assumed that 6.26% of projected FFS base drug expenditures will be collected as State supplemental rebates.

4. Family planning drugs account for 0.010% of rebates and are funded with 90% federal funds and 10% General Fund.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 59

5. The mandatory ACA population collections is estimated to be $26,093,000 for FY 2014-15 and $28,740,000 for FY 2015-16 annually and will be 100% FFP.

	FY 2014-15		FY 2015-16	
	TF	GF	TF	GF
Title XIX 50/50	($131,636,000)	($65,818,000)	($144,812,000)	($72,406,000)
Title XIX 10/90	($16,000)	($2,000)	($18,000)	($2,000)
100% Title XIX	($26,093,000)	($0)	($28,740,000)	($0)
Total	**($157,745,000)**	**($65,820,000)**	**($173,570,000)**	**($72,408,000)**

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

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	4/2004
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1182

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$196,000,000	-$170,000,000
- STATE FUNDS	-$97,992,000	-$84,993,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$196,000,000	-$170,000,000
STATE FUNDS	-$97,992,000	-$84,993,200
FEDERAL FUNDS	-$98,008,000	-$85,006,800

DESCRIPTION

Purpose:
This policy change estimates the recovery of monies due to the resolution of aged and disputed drug rebate payments for the State Supplemental, Federal, Breast and Cervical Cancer Treatment Program (BCCTP), Family Planning, Access, Care and Treatment (FPACT), and Managed Care Organizations (MCO) rebate programs.

Authority:
Welfare & Institutions Code, Section 14105.33

Interdependent Policy Changes:
PC 59 State Supplemental Drug Rebates
PC 61 Federal Drug Rebate Program
PC 55 BCCTP Drug Rebates
PC 58 Family PACT Drug Rebates

Background:
Aged Rebates
Between 1991 and 2002, the Medi-Cal program accumulated large rebate disputes with participating drug companies for which the Department was cited in an audit of the rebate program by the Office of Inspector General (OIG). The Legislature approved funding in the Budget Act of 2003 for the Department to add additional staff to resolve aged drug rebate payment disputes.

Disputed Rebates
Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are being defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and receive payments.

MCO Rebates
The aged and disputed rebates associated with the MCOs will be included in this PC but identified separately for tracking purposes until the end of FY 2014-15.

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 60

Reason for Change from Prior Estimate:
The amount of family planning drugs has decreased.

Methodology:

1. For MCO related Aged and Disputed Rebates, it is estimated that the Department will collect $66,000,000 FY 2014-15.

2. For non-MCO Aged and Disputed Rebates, it is estimated that the Department will collect $130,000,000 in FY 2014-15.

3. For FY 2015-16, it is estimated that the Department will collect $170,000,000 in aged and disputed rebates.

4. Beginning in FY 2015-16, the aged and disputed rebates will no longer be subdivided into MCO and non-MCO categories. Also, the overall aged and disputed rebates will decrease as the initial retroactive MCO rebates have been processed.

5. The family planning drug portion accounts for 0.01% of the rebates. This is funded at 90% FFP and 10% GF.

	TF	GF	FF
FY 2014-15 (50/50 FFP)	$ 195,980,000	$ 97,990,000	$ 97,990,000
FY 2014-15 (10/90 FFP)	$ 20,000	$ 2,000	$ 18,000
	$ 196,000,000	**$ 97,992,000**	**$ 98,008,000**

	TF	GF	FF
FY 2015-16 (50/50 FFP)	$ 169,983,000	$ 84,991,500	$ 84,991,500
FY 2015-16 (10/90 FFP)	$ 17,000	$ 1,700	$ 15,300
	$ 170,000,000	**$ 84,993,200**	**$ 85,006,800**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	7/1990
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	55

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$1,150,414,000	-$1,265,829,000
- STATE FUNDS	-$480,014,600	-$528,063,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,150,414,000	-$1,265,829,000
STATE FUNDS	-$480,014,600	-$528,063,700
FEDERAL FUNDS	-$670,399,400	-$737,765,300

DESCRIPTION

Purpose:
This policy change estimates the revenues collected from the Federal Drug rebates.

Authority:
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.

Interdependent Policy Changes:
Not Applicable

Background:
The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs.

Reason for Change from Prior Estimate:
The collection projections were revised based on additional actual data from January 2014 to June 2014.

Methodology:
1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

2. FFS drug expenditures are declining because of the shift of Medi-Cal beneficiaries into managed care.

3. In FY 2014-15 and FY 2015-16, it is assumed that 53.56% of projected FFS base drug expenditures will be collected as rebates.

4. Family planning drugs account for 0.010% of rebates and are funded with 90% federal funds and 10% General Fund.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 61

5. The mandatory ACA population collections is estimated to be $190,292,000 for FY 2014-15 and $209,600,000 for FY 2015-16 and will be 100% FFP.

	FY 2014-15		
	TF	**GF**	**FFP**
50% Title XIX / 50% GF	($960,006,000)	($480,003,000)	($480,003,000)
90% Title XIX / 10% GF	($116,000)	($12,000)	($104,000)
100% Title XIX FFP	($190,292,000)	$0	($190,292,000)
Total	**($1,150,414,000)**	**($480,015,000)**	**($670,399,000)**

	FY 2015-16		
	TF	**GF**	**FFP**
50% Title XIX / 50% GF	($1,056,102,000)	($528,051,000)	($528,051,000)
90% Title XIX / 10% GF	($127,000)	($13,000)	($114,000)
100% Title XIX FFP	($209,600,000)	$0	($209,600,000)
Total	**($1,265,829,000)**	**($528,064,000)**	**($737,765,000)**

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

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1723

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$3,036,000	$3,036,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,036,000	$3,036,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,036,000	$3,036,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for cost settlements to counties and contracted providers for payments related to Drug Medi-Cal (DMC) services.

Authority:
Welfare & Institutions Code 14124.24 (g)(1)
Title 22, California Code of Regulations 51516.1

Interdependent Policy Changes:
Not Applicable

Background:
The DMC program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, providers for non-Narcotic Treatment Program services must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE).

Reimbursement for non-Narcotic Treatment Program services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service.

Reimbursement for Narcotic Treatment Program services is limited to the lowest of the following costs:

- Provider's usual and customary charge to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 66

Narcotic treatment programs that do not receive federal Substance Abuse Prevention and Treatment block grant funds are not required to submit cost data.

Effective July 1, 2011, the funds to cover the non-federal share of costs were realigned to counties as County Funds (CF).

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

Methodology:

1. The interim cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.

2. Final cost settlements are based on comparing actual expenditures against audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.

3. Costs are estimated to total $3,429,000 for FY 2014-15 and FY 2015-16. In the FY 2011-12, the General Funds (GF) were replaced by County Funds (CF).

FY 2011-12 Settlements	**TF**	**CF**	**FF**
Regular	$3,206,000	$398,000	$2,808,000
Perinatal	$223,000	($5,000)	$228,000
Total for FY 2014-15	$3,429,000	$393,000	**$3,036,000**

FY 2012-13 Settlements	**TF**	**CF**	**FF**
Regular	$3,206,000	$398,000	$2,808,000
Perinatal	$223,000	($5,000)	$228,000
Total for FY 2015-16	$3,429,000	$393,000	**$3,036,000**

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

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	7/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1724

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$5,398,000
- STATE FUNDS	$0	$793,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$5,398,000
STATE FUNDS	$0	$793,000
FEDERAL FUNDS	$0	$4,605,000

DESCRIPTION

Purpose:
This policy change budgets the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:
Welfare & Institutions Code 14021.51; 14021.6 (b)(1); 14021.9 (c); and 14105 (a)
Title 22, California Code of Regulations, Section 51516.1 (a)(g)

Interdependent Policy Changes:
Not Applicable

Background:
Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. The proposed DMC rates are based either on the developed rates for use in FY 2015-16 or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- Narcotic Treatment Program (NTP) – Dosing
- NTP - Individual Counseling
- NTP - Group Counseling
- Intensive Outpatient Treatment, previously Day Care Rehabilitative
- Naltrexone Treatment Service
- Residential Treatment, previously Perinatal Residential
- Outpatient Drug Free (ODF) - Individual Counseling
- ODF- Group Counseling

For FY 2014-15, the DMC reimbursement rate was adjusted to eliminate the 10% county administration cost component for the Narcotic Treatment Program daily methadone dosing service, and to eliminate the county administration costs as reported in the annual cost report for the other DMC services. The adjusted reimbursement rate funds the direct treatment service costs only. The county

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 67

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 Escalation factors were updated and increased the CIP deflator to 12.4% from 12.1% and rate impact of new beneficiaries from Residential Treatment Services increased the DMC rate adjustment.

Methodology:
1. The CIP deflator used in calculating the proposed FY 2015-16 DMC rate is 12.4%. This is comprised of:
    - 10.1% for the change from FY 2009-10 to FY 2014-15, and
    - 2.3% assumed for the change from FY 2014-15 to FY 2015-16.

Regular Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2015-16 Rates *	FY 2015-16 Developed Rates	FY 2015-16 Required Rates
NTP-Dosing	$11.34	12.40%	$12.75	$11.44	$11.44
NTP-Individual	$13.30	12.40%	$14.95	$13.39	$13.39
NT- Group	$3.14	12.40%	$3.53	$3.02	$3.02
Intensive Outpatient	$61.05	12.40%	$68.62	$58.30	$58.30
Naltrexone	$19.07	12.40%	$21.43	$19.06	$19.06
ODF-Individual	$66.53	12.40%	$74.78	$66.93	$66.93
ODF-Group	$28.27	12.40%	$31.78	$27.14	$27.14

Perinatal Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2015-16 Rates *	FY 2015-16 Developed Rates	FY 2015-16 Required Rates
NTP-Dosing	$12.21	12.40%	$13.72	$13.88	$13.72
NTP-Individual	$19.04	12.40%	$21.40	$28.84	$21.40
NTP- Group	$6.36	12.40%	$7.15	$5.79	$5.79
Intensive Outpatient	$73.04	12.40%	$82.10	$88.43	$82.10
Residential Treatment	$89.90	12.40%	$101.05	$115.02	$101.05
ODF-Individual	$95.23	12.40%	$107.04	$144.19	$107.04
ODF-Group	$57.26	12.40%	$64.36	$52.11	$52.11

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

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 67

2. The incremental difference between FY 2014-15 required rates and FY 2015-16 required rates are:

Regular Services	FY 2014-15 Required Rates	FY 2015-16 Required Rates	Incremental Difference
NTP-Dosing	$10.80	$11.44	$0.64
NTP- Individual	$13.48	$13.39	($0.09)
NTP-Group	$2.91	$3.02	$0.11
Intensive Outpatient	$56.44	$58.30	$1.86
Naltrexone	$19.06	$19.06	$0.00
ODF-Individual	$67.38	$66.93	($0.45)
ODF-Group	$26.23	$27.14	$0.91

Perinatal Services	FY 2014-15 Required Rates	FY 2015-16 Required Rates	Incremental Difference
NTP-Dosing	$11.79	$13.72	$1.93
NTP-Individual	$21.06	$21.40	$0.34
NTP-Group	$7.03	$5.79	($1.24)
Intensive Outpatient	$80.78	$82.10	$1.32
Residential Treatment	$99.43	$101.05	$1.62
ODF-Individual	$105.32	$107.04	$1.72
ODF-Group	$63.33	$52.11	($11.22)

3. The cost estimate is developed by the following:

   Caseload x Units of Service (UOS) x Rates

4. The incremental rate change on an accrual basis is shown below:

Regular (Program 20)	
Narcotic Treatment	$4,901,119
Intensive Outpatient	$3,491,680
Outpatient Drug Free	$1,526,016
Residential Treatment	$277,666
Total for Regular	$10,196,481
Perinatal (Program 25)	
Narcotic Treatment	$52,780
Intensive Outpatient	$78,518
Outpatient Drug Free	($176,086)
Residential Treatment	$258,025
Total for Perinatal	$213,237

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 67

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

	Accrual	FY 2015-16	FY 2016-17
Regular	$10,196,481	$7,647,361	$2,549,120
Perinatal	$213,237	$159,927	$53,309
Total	$10,409,718	$7,807,288	$2,602,429

6. The annual rate adjustment for FY 2015-16 is:

	Total	**GF**	**FF**	CF*
FY 2015-16	$7,807,288	**$793,693**	**$4,604,693**	$2,408,902

*County funds are not budgeted.

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

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1759

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$91,236,000	$93,734,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$91,236,000	$93,734,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$91,236,000	$93,734,000

DESCRIPTION

Purpose:
This policy change estimates the elimination of the state maximum rates for Medi-Cal specialty mental health services (SMHS).

Authority
AB 1297 (Chapter 651, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The Welfare and Institution (W&I) Code, sections 5720 and 5724, limited reimbursement of SMHS to the state maximum rates. The state maximum rate is a schedule of maximum allowances (SMA) for SMHS. AB 1297 amended W&I Code, sections 5720 and 5724 to change the manner in which SMHS are reimbursed. AB 1297 requires the Department to reimburse mental health plans based upon the lower of their certified public expenditures or the federal upper payment limit. The federal upper payment limit will be equal to the aggregate allowable cost or customary charge for all SMHS provided by the mental health plan and its network of providers. These changes to the reimbursement methodology will result in an increase of federal reimbursement to mental health plans for SMHS. The elimination of the state maximum rate was implemented in the Short-Doyle/Medi-Cal (SD/MC) claiming system in fiscal year 2012-13.

Reason for Change from Prior Estimate:
The change is due to a change in methodology. This estimate is based on FY 2013-14 claims data and actual claiming patterns.

Methodology:
1. The costs are developed using FY 2012-13 and FY 2013-14 approved claims from each county that were paid in FY 2013-14.

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 71

2. The approved units, by county and type of services, were multiplied by the SMA rate that would have been in place in FY 2012-13 and FY 2013-14 to calculate the SMA limit.

3. The SMA limit was subtracted from the approved amount by county and service type to calculate the approved amount in excess of the SMA for FY 2012-13 and FY 2013-14 approved claims paid in FY 2013-14.

(Dollars in Thousands)

	Approved Claims in Excess of SMA	FF in Excess of SMA
FY 2012-13	$72,630	$36,315
FY 2013-14	$105,402	$52,701
Total	$178,032	$89,016

4. The FY 2013-14 actual approved claims were increased by the percentage change in the medical component of the Consumer Price Index to estimate the impact of the elimination of SMA rates in FY 2014-15 and FY 2015-16.

(Dollars In Thousands)

	FF	COLA	Increase
FY 2013-14	$89,016	2.49%	$2,220
FY 2014-15	**$91,236**	2.74%	$2,498
FY 2015-16	**$93,734**		

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

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1719

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$42,008,000	$42,520,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$42,008,000	$42,520,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$42,008,000	$42,520,000

DESCRIPTION

Purpose:
This policy change estimates the federal reimbursement for specialty mental health benefits associated with transitioning the Healthy Families Program (HFP) subscribers into the Medi-Cal program.

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

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to AB 1494, HFP subscribers were transitioned into the Medi-Cal program using a phased-in approach that began January 2013 and concluded November 2013. Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) enrollees were carved out of the HFP and provided by county mental health plans. The Medi-Cal program does not have an “SED carve-out,” but it does carve out from Medi-Cal managed care plans any mental health services beyond what a primary care physician can provide within their scope of practice; this includes Medi-Cal specialty mental health services. Children that transitioned from the HFP to Medi-Cal have access to the carved-out Medi-Cal specialty mental health services provided by county mental health plans if they meet medical necessity criteria for those services. County mental health plans are eligible to claim federal financial participation (FFP) through the Certified Public Expenditure (CPE) process.

HFP subscribers that transitioned into the Medi-Cal program are considered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible and can receive the full array of Medi-Cal specialty mental health services based on medical necessity and their mental health needs.

Reason for Change from Prior Estimate:
Expenditures have been revised based on the updates to HFP claim lag.

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 72

Methodology:

1. Beginning January 1, 2013, HFP subscribers transitioned to Medi-Cal.

2. The majority of mental health services provided to current SED enrollees will continue under the Medi-Cal specialty mental health services. As such, the current SED expenditures shifted from the HFP Families – SED policy change to the Children's SMHS policy changes.

3. Additional EPSDT clients may be served by the mental health plans as a result of changing from SED criteria to Medi-Cal medical necessity criteria, which will increase utilization of Medi-Cal specialty mental health services.

4. Additional psychiatric inpatient services will be provided by the mental health plans that were previously covered by the HFP managed care plans.

(In Thousands)

	TF	FFP	County
SED Services	$35,718	$23,217	$12,501
Outpatient	$48,699	**$31,654**	$17,045
Inpatient	$15,929	**$10,354**	$5,575
FY 2014-15	$100,346	$65,225	$35,121

(In Thousands)

	TF	FFP	County
SED Services	$37,932	$24,656	$13,276
Outpatient	$49,292	**$32,040**	$17,252
Inpatient	$16,123	**$10,480**	$5,643
FY 2015-16	$103,347	$67,176	$36,171

Funding:

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

KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	1/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1718

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$27,247,000	$36,192,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$27,247,000	$36,192,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$27,247,000	$36,192,000

DESCRIPTION

Purpose:
This policy change estimates the increase in costs due to the *Katie A. v. Diana Bontá* lawsuit.

Authority:
Katie A. v. Diana Bontá

Interdependent Policy Changes:
Not Applicable

Background:
On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. Since October 13, 2011, the parties have met with the Special Master to develop a plan for settlement implementation. As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive an increase in existing services that will be provided in a more intensive and effective manner. In this context, these existing services are referred to as Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC). The ICC and IHBS were available effective January 1, 2013. TFC services are expected to begin January 1, 2015.

Reason for Change from Prior Estimate:
This estimate has been updated for an increase in the lag of claim payments and adjusts for delay in CMS approval of TFC from August 2014 to January 2015.

KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER: 73

Methodology:

1. The *Katie A*. cost estimate is based on two factors:

   - An increase in the penetration rate of children receiving specialty mental health services within the *Katie A*. subclass of clients; and

   - An increase in the cost of services per client for existing clients due to the availability of IHBS, ICC, and TFC.

2. This estimate assumes the increase in the cost of services per client for ICC, IHBS, and TFC.

3. The estimated annual cost for specialty mental health services (SMHS), excluding TFC, for new clients is $38,830,000 and the estimated annual increase in cost for existing clients is $14,672,000, giving a total annual cost of $53,502,000. These amounts are on an accrual basis.

4. Assume the additional services, excluding TFC, began January 1, 2013.

5. In FY 2012-13 assume the accrual estimate is half of the full year costs.

   $53,502,000 ÷ 12 months x 6 months = $26,751,000

6. Assume the additional TFC services have an annual cost of $15,723,000 and will begin on January 1, 2015.

7. In FY 2014-15 assume the accrual estimate for TFC is half of the full year costs.

   $15,732,000 ÷ 12 months x 6 months = $7,866,000

8. Assume there is a three month lag for TFC claims paid in the first year the services occur and the remainder will be paid in the following year.

   $7,866,000 ÷ 6 month x 3 months = $3,933,000

9. Based on historical claims received, assume 78% of the each fiscal year claims will be paid in the year the services occur. The following year, 21% is paid and in the third year, 1% is paid.

(In Thousands)

Cash Estimate	TF	FF	County
FY 2012-13	$268	$134	$134
FY 2013-14	$11,235	$5,618	$5,617
FY 2014-15	$42,990	$21,495	$21,495
FY 2014-15	$54,493	**$27,247**	$27,246
FY 2013-14	$535	$268	$267
FY 2014-15	$17,844	$8,922	$8,922
FY 2015-16	$54,003	$27,002	$27,001
FY 2015-16	$72,382	**$36,192**	$36,190

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 7/2015
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1713

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$27,375,000
- STATE FUNDS	$0	$23,830,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$27,375,000
STATE FUNDS	$0	$23,830,000
FEDERAL FUNDS	$0	$3,545,000

DESCRIPTION

Purpose:
This policy change estimates the interim and final cost settlements for specialty mental health services (SMHS).

Authority:
Welfare & Institution Code 14705(c)
Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim settlements to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended county cost report the MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 74

Methodology:

1. Interim cost settlements are based on the difference between each county MHP's filed cost report and the payments they received from the Department.

(Dollars in Thousands)

	Underpaid	Overpaid	Net
Interim Settlement (FY 2009-10)			
Children and Adults	$35,025	($3,661)	$31,364
ARRA	$2,551	($834)	$1,717
M-CHIP*	$297	($555)	($258)
BCCTP	$0	($30)	($30)
Refugees	$1	($1)	$0
Healthy Families*	$21	($1,055)	($1,034)
Final Settlement (Multi-Years)			
Children and Adults	$2,774	($7,086)	($4,312)
Healthy Families*	$21	($93)	($72)
Total FY 2015-16	$40,690	($13,315)	$27,375

2. Final cost settlements are based on the difference between each county MHP's final audited cost report and the payments they received from the Department.

3. Cost settlements for services, administration, utilization review/quality assurance, and mental health Medi-Cal administrative activities are each determined separately.

4. Cost settlements prior to 2011 Realignment may consist of General Fund (GF) and Federal Funds (FF).

(Dollars In Thousands)

	TF	GF	FF
Children and Adults	$27,052	$23,830	$3,222
ARRA	$1,717	$0	$1,717
M-CHIP*	($258)	$0	($258)
BCCTP	($30)	$0	($30)
Healthy Families*	($1,106)	$0	($1,106)
Total FY 2015-16	**$27,375**	**$23,830**	**$3,545**

Funding:

Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)*
100% General Fund (4260-101-0001)

INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	1/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1805

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$9,672,000	$12,276,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,672,000	$12,276,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,672,000	$12,276,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for mobile crisis support teams and triage personnel to enhance mental health services for community wellness.

Authority:
SB 82 (Chapter 34, Statutes of 2013) Investment in Mental Health Wellness Act of 2013

Interdependent Policy Changes:
Not Applicable

Background:
The Investment in Mental Health Wellness Act of 2013 specifies to add 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds over the next two years to expand community-based resources and capacity. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders. The California Health Facilities Financing Authority (CHFFA) within the State Treasurer's Office will implement grant programs for one-time funding to build supporting infrastructure. The CHFFA approved twenty grant applications for mobile crisis support teams, crisis stabilization beds, and crisis residential treatment beds as of April 2014. The anticipated federal fund reimbursements are $2.8 million for the mobile crisis support services.

This Act also specifies to add at least 600 triage personnel over the next two years to assist individuals in gaining access to medical, specialty mental health care, alcohol and drug treatment, social, educational, and other services. The Mental Health Services Oversight and Accountability Commission (MHSOAC) will implement an allocation process based on funding applications for Mental Health Services Act funds totaling $32 million. The majority of the triage personnel costs are assumed to be Medi-Cal reimbursable. The total estimated federal reimbursement is $22 million annually. The initial triage personnel grants were awarded to 22 counties in January 2014.

INVESTMENT IN MENTAL HEALTH WELLNESS

REGULAR POLICY CHANGE NUMBER: 75

Reason for Change from Prior Estimate:
The estimate has been updated with payment lags based on paid claims data.

Methodology:
1. The federal portion of the accrual estimate is shown below:

(Dollars In Thousands)

	FY 2014-15	FY 2015-16
Mobile Crisis Teams	$2,800	$2,800
600 Triage Personnel	$22,000	$22,000
Total	**$24,800**	**$24,800**

2. On a cash basis, the Department will pay 78% of each fiscal year claims in the year services occur, 21% will be paid in the second year, and 1% in the third year.

(Dollars In Thousands)

	TF	FFP	CF
FY 2014-15	$19,344	**$9,672**	$9,672
FY 2015-16	$24,552	**$12,276**	$12,276

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

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1712

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$4,095,000	$186,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,095,000	$186,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,095,000	$186,000

DESCRIPTION

Purpose:
This policy change estimates the costs of providing services to Healthy Families enrollees who are Seriously Emotionally Disturbed (SED).

Authority:
California Insurance Code 12693.61 and 12694.1

Interdependent Policy Changes:
Not Applicable

Background:
The Healthy Families Program (HFP) provides low cost insurance for eligible children under the age of 19 whose families:

- Do not have health insurance,
- Do not qualify for zero share of cost Medi-Cal,
- Income is at or below 250 percent of the federal poverty level.

Mental health services for the HFP subscribers who are SED are “carved-out” of the HFP managed care health plans’ array of covered services and are provided by county mental health departments. County mental health departments are responsible for the provision and payment of all treatment of SED conditions, with the exception of the first thirty days of psychiatric inpatient services per benefit year, which remain the responsibility of the HFP health plan. This covered benefit is referred to as the “HFP SED benefit.”

When a county mental health department assumes responsibility for the treatment of the HFP subscriber’s SED condition, it can submit claims to obtain federal reimbursement for the services. County mental health departments receive 65% federal funds participation (FFP) reimbursement for services provided to HFP subscribers and pay for the 35% match with realignment dollars or other local funds. The costs associated with the HFP SED benefit will be reflected in the Specialty Mental Health Services for Children policy change.

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 76

On December 31, 2012, HFP stopped enrolling new subscribers and the current HFP subscribers began transitioning into the Medi-Cal program in phases. The last group of HFP children transitioned to Medi-Cal on November 1, 2013.

Reason for Change from Prior Estimate:
The changes are a result of updated HFP claim lag.

Methodology:

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

2. Due to the lag in reporting of claims data, the most recent six months of data must be weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.

3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.

4. Medi-Cal Specialty Mental Health programs costs are shared between FFP and a county match. State Children's Health Insurance Program (S-CHIP) claims are eligible for federal reimbursement of 65%.

5. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

Accrual Estimate	TF	FFP	County
FY 2012-13	$29,245	$19,009	$10,236
FY 2013-14	$28,609	$18,596	$10,013
FY 2014-15	$0	$0	$0
FY 2015-16	$0	$0	$0

6. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims and 21% of FY 2013-14 SD/MC claims.

(Dollars In Thousands)

Cash Estimate	TF	FFP	County
FY 2012-13	$292	$190	$102
FY 2013-14	$6,008	$3,905	$2,103
FY 2014-15	$0	$0	$0
TOTAL FY 2014-15	$6,300	**$4,095**	$2,205

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 76

7. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 SD/MC claims.

(Dollars In Thousands)

Cash Estimate	TF	FFP	County
FY 2013-14	$286	$186	$100
FY 2014-15	$0	$0	$0
FY 2015-16	$0	$0	$0
TOTAL FY 2015-16	$286	**$186**	$100

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

OVER ONE-YEAR CLAIMS

REGULAR POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1717

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$3,585,000	$942,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,585,000	$942,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,585,000	$942,000

DESCRIPTION

Purpose:
This policy change estimates the cost of claims that are submitted by county mental health plans for late eligibility determinations.

Authority:
Title 22, California Code of Regulations 50746 and 51008.5
Welfare & Institutions Code 14680-14685.1
Specialty Mental Health Services Consolidation Waiver

Interdependent Policy Changes:
Not Applicable

Background:
County mental health plans have begun submitting Medi-Cal specialty mental health service claims for clients with Letters of Authorization for late eligibility determinations. When an over one-year claim is determined as eligible by the Department, the county has 60 days to submit the claim for payment.

Reason for Change from Prior Estimate:
FY 2013-14 costs shifted to FY 2014-15 due to a delay in the implementation process and a delay in claims being paid as anticipated.

Methodology:
1. One-year claims are based on actual claims received from the counties.

	TF	FFP	County
FY 2014-15	$7,170,000	**$3,585,000**	$3,585,000
FY 2015-16	$1,884,000	**$942,000**	$942,000

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

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 7/2015
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1458

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$417,023,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$417,023,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$417,023,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health Services (SMHS).

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
Welfare & Institution Code 14723

Interdependent Policy Changes:
Not Applicable

Background:
State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

The supplemental payment State Plan Amendment (SPA) and Certified Public Expenditure Protocol are pending approval from the Centers for Medicare and Medicaid Services (CMS).

Reason for Change from Prior Estimate:
Supplemental payments for FYs 2008-09, 2009-10, 2010-11 and 2011-12 shifted to FY 2015-16 pending SPA approval.

Methodology:
1. The unreimbursed costs for county-operated providers was calculated based on the difference between the county operated provider's gross allowable cost and the gross schedule of statewide maximum allowance (SMA).

2. The amount of unreimbursed costs was increased by the ratio of county costs to total mental health plan costs to account for unreimbursed costs for contract providers.

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 78

3. The FY 2008-09 estimates were developed using the final filed cost reports received from each county mental health plan.

4. The FY 2009-10 estimates were developed using the final filed cost reports received from each county and are still under Department review.

5. Assume the FY 2010-11 supplemental payments will increase by 10% from the payment for FY 2009-10 and the FY 2011-12 supplemental payments will increase by 10% from the payment for FY 2010-11.

(Dollars In Thousands)

	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2008-09 FFP	$52,103	$12,079	$64,187
FY 2009-10 FFP	$90,402	$20,484	$110,886
FY 2010-11 FFP	$95,008	$22,532	$117,540
FY 2011-12 FFP	$124,410	$0	$124,410
Total for FY 2015-16	$361,923	$55,095	**$417,023**

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

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 1/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1660

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$2,397,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$2,397,000	$0
FEDERAL FUNDS	-$2,397,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of federal financial participation (FFP) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:
Title 42, United States Code (USC) 1396b (d)(2)(C)

Interdependent Policy Changes:
Not Applicable

Background:
During the audit and cost settlement process, the Department identified overpayments to Siskiyou County Mental Health Plan as a result of improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FFP to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department in the amount of $200,000 per year until it fulfills its obligation for repayment. The County has submitted two payments totaling $400,000.

Reason for Change from Prior Estimate:
Payment was made to CMS and reduces the amount due to the Department. In FY 2014-15 a cost settlement increased the repayment amount due to CMS.

Methodology:
1. The Department began making repayments to CMS in January 2012.

2. In FY 2014-15, a repayment amount of $1,131,000 was added as a result of a chart review audit disallowing service claims for Heal Therapy and an additional $1,266,000 was added for a cost settlement for FY 2009-10.

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 79

3. Siskiyou County will reimburse the GF $200,000 annually. The total FF repayment due from the County totals $8,470,000. The Department will continue to repay CMS for overpayments within one year of discovery. In FY 2014-15, $2,397,000 will be paid from the GF. Reimbursements are shown in the Management Summary.

Date of Overpayment Discovery	Due to DHCS	FY 2014-15 GF Due to CMS	FY 2015-16	
8/4/2011	$2,090,000			
11/15/2011	$586,000			
12/21/2011	$95,000			
3/26/2012	$443,000			
1/30/2013	$2,859,000			
5/30/2013	$1,131,000	$1,131,000		
3/24/2014	$1,266,000	$1,266,000		
Total:	$8,470,000	**$2,397,000**		
		($200,000)	**($200,000)**	Reimbursement

Funding:
GF (4260-101-0001)
Title XIX FF (4260-101-0890)
Reimbursement GF (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/1999
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	35

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$8,000,000	$3,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$8,000,000	$3,000,000
FEDERAL FUNDS	-$8,000,000	-$3,000,000

DESCRIPTION

Purpose:
This policy change estimates the cost of federal financial participation (FFP) repayments that the Department must make to the Centers for Medicare and Medicaid Services (CMS) for inappropriately claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs).

Authority:
Title 42, Code of Federal Regulations 435.1009
Welfare & Institutions Code 14053.3

Interdependent Policy Changes:
Not Applicable

Background:
Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for federal reimbursement. Identifiers are currently not available in MEDS to indicate whether a Medi-Cal beneficiary is residing in an IMD. Consequently, the Department's Fiscal Intermediary (FI) may not deny any claims that are ineligible for reimbursement for this reason. The Department uses data from the mental health Client Services Information (CSI) system to retrospectively identify the dates individuals were residents of an IMD for repayment of the FFP, as required by the Centers for Medicare & Medicaid Services (CMS). This information is not known at the time the claims were processed and paid by the FI. The Department matches the data from the CSI system to the claims data to determine which claims were inappropriately reimbursed while the individual was a resident of an IMD.

While the Department intends to develop eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services, the current inappropriately paid services must be repaid to CMS.

Reason for Change from Prior Estimate:
The claiming data has been updated with the most recent data to estimate the amount of ancillary

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 80

services provided to beneficiaries residing in an IMD. Due to the County of Colusa Court of Appeals decision on July 9, 2014, the counties will not reimburse the State for IMD ancillary costs.

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

2. The FFP repayment to CMS for FY 2014-15 and FY 2015-16 is:

(Dollars in Thousands)

Services Received	FY 2014-15	FY 2015-16
10/01/10 - 09/30/11	$8,000	$0
10/01/11 - 09/30/12	$0	$3,000
Total	**$8,000**	**$3,000**

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

CHART REVIEW

REGULAR POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1714

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$1,807,000	-$795,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$1,807,000	-$795,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$1,807,000	-$795,000

DESCRIPTION

Purpose:
This policy change estimates the recoupments due to the Department from disallowed claims. The disallowed claims are the result of the on-site chart reviews of inpatient and outpatient mental health providers.

Authority:
Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:
Not Applicable

Background:
Since January 2005, the Department has been conducting on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries.

Reason for Change from Prior Estimate:
There is a backlog of recoupments from prior years that increased the estimate for FY 2014-15.

Methodology:
1. The FY 2014-15 estimate includes recoupments from chart reviews conducted in FY 2013-14 and an estimate of recoupments from chart reviews to be conducted in FY 2014-15.

2. The FY 2015-16 estimate includes recoupments from charts to be reviewed in FY 2015-16.

	TF	FFP
FY 2014-15	**($1,807,000)**	**($1,807,000)**
FY 2015-16	**($795,000)**	**($795,000)**

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

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2005
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1073

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,758,626,000	$1,753,168,000
- STATE FUNDS	$567,206,000	$566,513,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,758,626,000	$1,753,168,000
STATE FUNDS	$567,206,000	$566,513,000
FEDERAL FUNDS	$1,191,420,000	$1,186,655,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.6 and 14166.16
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1066 (Chapter 86, Statutes of 2011)
HR 4302 (2014)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. Non-emergency services for undocumented individuals are eligible for DSH program funding. The 2014-15 and 2015-16 DSH allotments are estimated to be $1,186,655,012.

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.

- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 82

- Private DSH hospitals, under the Special Terms and Conditions and SPA 05-22, are allocated a total of $160.00 from the federal DSH allotment and State General Fund (GF) each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010, continuing the same DSH payment methodology from the MH/UCD.

AB 1066 provides the authority for the Department to implement the new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

The Affordable Care Act (ACA) reduction in the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, HR 4302 (2014) was enacted on April 1, 2014, which delays the reduction until October 1, 2016.

The California Bridge to Reform Section 1115(a) Medicaid Demonstration will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

Reason for Change from Prior Estimate:
Payments for FY 2011-12, FY 2012-13, and FY 2013-14 were updated to be paid in FY 2014-15.

Methodology:
It is assumed that the DSH payments will be made as follows on a cash basis:

FY 2014-15	TF	GF***	FF	IGT**
DSH 2011-12	$346,000	($69,000)	$278,000	$137,000
DSH 2012-13	$4,091,000	$1,229,000	$2,352,000	$510,000
DSH 2013-14	$147,118,000	$1,351,000	$101,022,000	$44,745,000
DSH 2014-15	$1,607,071,000	$11,917,000	$1,087,767,000	$507,387,000
Total FY 2014-15*	**$1,758,626,000**	**$14,428,000**	**$1,191,419,000**	**$552,779,000**

FY 2015-16	TF	GF***	FF	IGT**
DSH 2014-15	$146,097,000	$1,083,000	$98,888,000	$46,126,000
DSH 2015-16	$1,607,071,000	$11,917,000	$1,087,767,000	$507,387,000
Total FY 2015-16*	**$1,753,168,000**	**$13,000,000**	**$1,186,655,000**	**$553,513,000**

*Totals may differ due to rounding.

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

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	3/2011
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1570

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,399,432,000	$1,402,298,000
- STATE FUNDS	$699,716,000	$701,149,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,399,432,000	$1,402,298,000
STATE FUNDS	$699,716,000	$701,149,000
FEDERAL FUNDS	$699,716,000	$701,149,000

DESCRIPTION

Purpose:
This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's Designated Public Hospitals' (DPH) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.77
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010. The BTR establishes the DSRIP. AB 1066 provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payments to DPHs.

There are five categories for which funding is available under the DSRIP in the Medi-Cal program:

(1) Infrastructure Development
(2) Innovation and Redesign
(3) Population-focused Improvement
(4) Urgent Improvement in Care
(5) HIV Transition Projects

Category 5 payments are budgeted in the BTR—LIHP—DSRIP HIV Transition Projects policy change. DPHs submitted their DSRIP proposal for approval and are paid based on meeting milestones. DPHs provide the non-federal share of their DSRIP through IGTs.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 83

The total federal funding for DSRIP for categories 1-4 shall not exceed total computable expenditures of $6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable Federal Medical Assistance Percentage (FMAP) of annual total computable expenditure limits as follows:

(Dollars in Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	$1,006,880	$591,601
2011-12	$1,300,000	$650,000
2012-13	$1,400,000	$700,000
2013-14	$1,400,000	$700,000
2014-15	$1,400,000	$700,000
2015-16 (New Waiver)	$700,000	$350,000

Reason for Change from Prior Estimate:
Changes are due to updated projections for DY 2012-13, DY 2013-14, and DY 2014-15.

Methodology:

1. In DY 2011-12 and subsequent demonstration years, payments are expected to be made in April of the same fiscal year and October of the subsequent fiscal year.

2. For categories 1 and 2, hospitals that did not achieve full funding for DY 2010-11 through 2012-13 can claim the remaining funding until the end of the waiver, subject to the following carry forward limitations:
   - Carry forward funding from DY 2010-11 and DY 2011-12 is subject to a 10% penalty beginning January 1, 2014.
   - Carry forward funding from DY 2012-13 is subject to a 10% penalty beginning July 1, 2014.
   - The Special Terms and Conditions (STCs) of the BTR waiver do not allow funding to be carried forward in categories 1 and 2 for DY 2013-14 and DY 2014-15.
   - In DY 2010-11, DPHs claimed 100% of DSRIP funding in categories 1 and 2 so there are no carry forward funds associated with these years.

3. For categories 1 and 2, DPHs have 90 days from January 1, 2014 to claim the available carry forward funds for DY 2010-11 and DY 2011-12, and 90 days from July 1, 2014 to claim carry forward funds for DY 2012-13. Assume the DPHs will claim all of the available carry forward amounts.

4. The STCs do not allow carry forward funding associated with category 3.

5. The STCs allow DPHs to carry forward funding associated with category 4 through the end of the BTR waiver.

6. DPH payments on a cash basis for FY 2014-15 and FY 2015-16 include DSRIP claiming for DY 2014-15 and 2015-16 as well as carry forward claiming.

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 83

7. The STCs require the Department to report any unused DSRIP amounts eligible to be rolled over into the Safety Net Care Pool (SNCP) to CMS by January 1, 2015. The Department will request that these amounts be rolled to the SNCP to cover other safety net services.

8. For DY 2014-15, it is anticipated that hospitals will achieve 100% of funding for Category 4 and 99.5% of Categories 1, 2, and 3.

9. DY 2014-15 spans FY 2014-15 and FY 2015-16, and covers a total of 16 months. The Department assumes 6 months of DY 2014-15 will be claimed in FY 2014-15.

10. The BTR will end on October 31, 2015. The Department assumes that the BTR funding will continue in the subsequent waiver. The Department assumes that in FY 2015-16, payments will be made for the remaining 10 months of DY 2014-15 and 8 months of payments will be attributable to the subsequent waiver.

11. On a cash basis, DSRIP payments are estimated to be:

(Dollars in Thousands)

		TF	IGT	FF
FY 2014-15				
	DY 2012-13	$24,992	$12,496	$12,496
	DY 2013-14	$586,958	$293,479	$293,479
	DY 2014-15	$787,482	$393,741	$393,741
		$1,399,432	**$699,716**	**$699,716**
FY 2015-16				
	DY 2013-14	$93,860	$46,930	$46,930
	DY 2014-15	$608,438	$304,219	$304,219
	DY 2015-16	$700,000	$350,000	$350,000
		$1,402,298	**$701,149**	**$701,149**

Funding:
50% Title XIX FF (4260-101-0890)
50% Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 84
IMPLEMENTATION DATE: 7/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1071

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$599,313,000	$545,435,000
- STATE FUNDS	$299,656,500	$272,717,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$599,313,000	$545,435,000
STATE FUNDS	$299,656,500	$272,717,500
FEDERAL FUNDS	$299,656,500	$272,717,500

DESCRIPTION

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

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
HR 4302 (2014)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously in effect for the 2004-05 fiscal year. These payments along with $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute.

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

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 84

The Affordable Care Act (ACA) reduction to the DSH allotments was previously scheduled to go into effect on October 1, 2013: instead, HR 4302 (2014) was enacted on April 1, 2014, which delays the reduction until October 1, 2016. The private DSH replacement payments are affected because, as required by SB 1100, the methodology to determine the DSH replacement payments is based on the DSH allotment.

Reason for Change from Prior Estimate:
FY 2012-13 and FY 2013-14 payments have been updated to be paid in FY 2014-15.

Methodology:
1. The remaining balance of 2009-10, 2010-11, 2011-12, 2012-13, and 2013-14 final payments are assumed to be paid in FY 2014-15.

2. SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by $21 million TF ($10.5 million GF) in 2012-13 and $10.5 million TF ($5.25 million GF) in 2013-14.

3. The California Bridge to Reform Section 1115(a) Medicaid Demonstration will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2014-15	**TF**	**GF**	**FF**
FY 2009-10	$989,000	$494,500	$494,500
FY 2010-11	$1,415,000	$707,500	$707,500
FY 2011-12	$1,696,000	$848,000	$848,000
FY 2012-13	$53,322,000	$26,661,000	$26,661,000
FY 2012-13 SB335 Adjustment	($1,871,000)	($935,500)	($935,500)
FY 2013-14	$44,578,000	$22,289,000	$22,289,000
FY 2013-14 SB335 Adjustment	($798,000)	($399,000)	($399,000)
FY 2014-15	$499,982,000	$249,991,000	$249,991,000
Total FY 2014-15	**$599,313,000**	**$299,656,500**	**$299,656,500**

FY 2015-16	**TF**	**GF**	**FF**
FY 2014-15	$45,453,000	$22,726,500	$22,726,500
FY 2015-16	$499,982,000	$249,991,000	$249,991,000
Total FY 2015-16	**$545,435,000**	**$272,717,500**	**$272,717,500**

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

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	7/2011
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1578

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$365,680,000	$3,412,258,000
- STATE FUNDS	$11,383,000	$1,534,672,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$365,680,000	$3,412,258,000
STATE FUNDS	$11,383,000	$1,534,672,000
FEDERAL FUNDS	$354,297,000	$1,877,586,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP was effective November 1, 2010, through December 31, 2013, under the BTR and consisted of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE covered eligible individuals with family incomes at or below 133% of Federal Poverty Level. The HCCI covered those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the HCCI (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use the following methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs),
- Intergovernmental Transfers for capitation rates payments (IGT-CAP), and
- IGTs for county-owned Federally Qualified Health Centers (IGT-FQHCs)

The Department has used the CI cost claiming protocol for the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) as the basis for payments made on claims for dates of service from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 85

Conditions under the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. CMS also approved the new cost claiming protocol for claims based on IGT-FQHC on February 5, 2013. The Department makes payments for dates of services beginning the second quarter of FY 2011-12 based on the new CPE cost claiming protocol.

The Department submitted a revised new cost claiming protocol for claims based on capitation rates for health care services provided to only MCE enrollees on July 1, 2014, and is currently waiting for CMS approval. The Department previously submitted the letters of Certification of Capitation Rates to CMS in August 2012, for the following eight local LIHPs: Alameda, Los Angeles, Kern, Riverside, San Bernardino, San Francisco, Santa Clara, and San Mateo. Since the submission of the letters in August 2012, Los Angeles County notified the Department they will not participate as a capitation rate LIHP.

Upon CMS approval of the capitation rate claiming protocol, the capitated rates, and the capitated rate contract amendments, these local LIHPs will receive payments based on approved capitation rates for health care services provided to their MCE population effective retroactively to July 1, 2011. Currently CMS has approved the capitation rates for these local LIHPs, but not approved the capitation rate protocol and the contract amendments.

The local LIHPs with CMS's approval to use the capitation payment mechanism for federal reimbursement of the MCE component of their program will continue to use CPEs to claim for reimbursement of their allowable health care services that are excluded from their capitation rates. The remaining local LIHPs will only use CPEs to claim for federal reimbursement. The MCE program is not subject to a federal funding cap.

Reason for Change from Prior Estimate:
The change is due to:

- A delay of protocol approval and claim processing,
- CPE reconciliations and all IGT-CAP payments delayed to FY 2015-16,
- Updated enrollment and capitation rate data, and
- Los Angeles County's formal notification they will not participate as a capitation rate LIHP.

Methodology:

1. The eight local LIHPs with approved capitation rates will continue to use CPEs for claiming federal reimbursement until CMS approves all capitation rate reimbursement documents. Once CMS approves the documents, the prior CPE-based payments retroactive to July 1, 2011 will be reconciled with the new capitation rate payments and the CPEs for excluded services.

2. Assume the IGT-CAP payments and reconciliation for FY 2011-12, FY 2012-13 and FY 2013-14 payments to the new capitated rates will occur in FY 2015-16.

3. IGT-FQHC payments are retroactive to July 1, 2011 or their LIHP implementation date if later. All payments are expected to be completed in FY 2014-15.

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 85

The estimated MCE payments on a cash basis are:

(Dollars in Thousands)

FY 2014-15	TF	IGT-CAP	IGT-FQHC	FFP	CPE*
2010-11 (CPEs)	$56,217			$56,217	$56,217
2011-12 (CPEs)	$83,250			$83,250	$83,250
2011-12 (IGT FQHC)	$19,842		$9,921	$9,921	
2012-13 (CPEs)	$65,542			$65,542	$65,542
2013-14 (CPEs)	$137,905			$137,905	$137,905
2013-14 (IGT FQHC)	$2,924		$1,462	$1,462	
Total**	**$365,680**	**$0**	**$11,383**	**$354,297**	**$342,914**

FY 2015-16	TF	IGT-CAP	IGT-FQHC	FFP	CPE*
2010-11 (CPEs)	$56,217			$56,217	$56,217
2011-12 (CPEs)	$83,250			$83,250	$83,250
2011-12 (IGT CAP)	$735,768	$367,884		$367,884	
2012-13 (CPEs)	$65,542			$65,542	$65,542
2012-13 (IGT-CAP)	$1,438,770	$719,385		$719,385	
2013-14 (CPEs)	$137,905			$137,905	$137,905
2013-14 (IGT-CAP)	$894,806	$447,403		$447,403	
Total**	**$3,412,258**	**$1,534,672**	**$0**	**$1,877,586**	**$342,914**

Funding:

LIHP IGT Fund (4260-607-8502)
100% Title XIX (4260-101-0890)

*Not included in TF.
**Amounts may differ due to rounding.

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1085

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$262,741,000	$344,803,000
- STATE FUNDS	$131,370,500	$172,401,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$262,741,000	$344,803,000
STATE FUNDS	$131,370,500	$172,401,500
FEDERAL FUNDS	$131,370,500	$172,401,500

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
AB 1467 (Chapter 23, Statutes of 2012), W&I Code 14166.14
State Plan Amendment 13-002

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals.

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund (GF), intergovernmental transfers (IGTs), and interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

SB 1100 requires the transfer of $118,400,000 annually from the General Fund (GF) (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. The distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100. Due to the inactivation of the Selective Provider Contracting

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 86

Program (SPCP); the Department will submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to continue the Private Hospital Supplemental Program and secure distributions from the Private Hospital Supplemental Fund for FY 2014-15.

Reason for Change from Prior Estimate:
The changes are due to updates to the FY 2013-14 balance, interest, IGTs, and program expenditures.

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs.
2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.
3. IGTs are estimated to total $24,667,000 in FY 2014-15 and $108,000,000 in FY 2015-16.
4. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
5. The BTR will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.
6. Martin Luther King Jr. Community Hospital is expected to reopen as a private hospital in south Los Angeles (LA) County. It will serve a high number of Medi-Cal beneficiaries once reopened and, with the assistance of LA County; IGTs will be obtained to maintain services.

It is assumed private hospital supplemental payments will be made on a cash basis as follows:

	TF	SF	FF
FY 2014-15			
FY 2013-14 Ending Balance	$982,000	$491,000	$491,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2013-14 interest	$292,000	$146,000	$146,000
IGT	$24,667,000	$12,333,500	$12,333,500
Total	$262,741,000	$131,370,500	$131,370,500
Cash Expenditures to Hospitals	**$262,741,000**	**$131,370,500**	**$131,370,500**
FY 2014-15 Ending Balance	$0	$0	$0
FY 2015-16			
FY 2014-15 Ending Balance	$0	$0	$0
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2014-15 interest	$3,000	$1,500	$1,500
IGT	$108,000,000	$54,000,000	$54,000,000
Total	$344,803,000	$172,401,500	$172,401,500
Cash Expenditures to Hospitals	**$344,803,000**	**$172,401,500**	**$172,401,500**
FY 2015-16 Ending Balance	$0	$0	$0

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 86

Funding:
100% GF (4260-105-0001)
Private Hospital Supplemental Fund (less funded by GF) (4260-698-3097)
50% Title XIX / 50% Private Hospital Supplemental Fund (4260-601-3097/4260-101-0890)

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	11/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1573

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$242,250,000	$122,917,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$242,250,000	$122,917,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$242,250,000	$122,917,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) for uncompensated care provided to individuals with no source of third party coverage for the services they receive.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.71
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after November 1, 2010 until October 31, 2015, based on the Special Terms and Conditions of the BTR, a new SNCP was established to support the provision of services to the uninsured. The SNCP is to be claimed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in Demonstration Year (DY) 6 of the BTR demonstration. This policy change estimates the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

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

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 87

Methodology:

1. Interim payments are made to the DPHs on a quarterly basis. The fourth quarter payment is split into two payments. Payments are made in October, January, April, June, and July. The June payment includes the months of April and May, while the July payment is for the month of June.

2. The BTR will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

3. Assume the duration of DY 2015-16 in the new waiver will be effective for an 8-month period from November 1, 2015 to June 30, 2016.

4. The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(Dollars in Thousands) **Demonstration Year**	**State-Only Funded Programs**	**Due to DPHs**
2010-11 (DY 6)	$400,000	$565,422
2011-12 (DY 7)	$400,000	$436,000
2012-13 (DY 8)	$400,000	$386,000
2013-14 (DY 9)	$400,000	$311,000
2014-15 (DY 10)	$400,000	$236,000
2015-16 (DY 11 New Waiver)	$0	$118,000

5. The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands) **Demonstration Year**	**FY 2014-15**	**FY 2015-16**
2013-14	$25,917	$0
2014-15	$216,333	$19,667
2015-16	$0	$103,250
Total	**$242,250**	**$122,917**

Funding:

100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1108

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$109,910,000	$6,882,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$109,910,000	$6,882,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$109,910,000	$6,882,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 93 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the CCS and GHPP from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the BTR allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The CCS and GHPP programs are included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 88

Reason for Change from Prior Estimate:
The change is due to updated DY 2014-15 program expenditures. In addition, claiming for DY 2014-15 will now occur in FY 2014-15 and FY 2015-16.

Methodology:

1. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF savings is reflected in the Family Health Estimate.

2. The final reconciliation for DY 2011-12 is anticipated to be completed in FY 2014-15. The Department estimates that it will have to repay the federal government $4.318 million in federal funds in FY 2014-15 for the DY 2011-12 final reconciliation.

3. The final reconciliation for DY 2012-13 is anticipated to be completed in FY 2015-16. The Department estimates that it will have to repay the federal government $31.2 million in federal funds in FY 2015-16 for the DY 2012-13 final reconciliation.

4. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP funding will not continue in the subsequent waiver.

The estimated CCS/GHPP federal reimbursements are:

(Dollars in Thousands)	CCS	GHPP	Total
FY 2005-06	$15,523	$8,485	$24,008
FY 2006-07	$46,856	$15,300	$62,156
FY 2007-08	$18,000	$8,000	$26,000
FY 2008-09	$20,958	$19,096	$40,054
FY 2009-10	$114,023	$43,313	$157,336
FY 2010-11	$96,910	$53,578	$150,488
FY 2011-12	$65,095	$30,351	$95,446
FY 2012-13	$67,718	$34,811	$102,529
FY 2013-14	$74,943	$47,438	$122,381

(Dollars in Thousands) **FY 2014-15**	CCS FF	GHPP FF	Total
DSHP-BTR (DY 2014-15)	$64,328	$49,900	$114,228
DY 2011-12 Final Reconciliation	($7,707)	$3,389	($4,318)
Total	**$56,621**	**$53,289**	**$109,910**
FY 2015-16			
DSHP-BTR (DY 2014-15)	$21,443	$16,633	$38,076
DY 2012-13 Final Reconciliation	($22,127)	($9,067)	($31,194)
Total	**($684)**	**$7,566**	**$6,882**

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 88

Funding:
100% Health Care Support Fund (4260-601-7503)

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 7/2012
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1622

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$92,162,000	$213,326,000
- STATE FUNDS	$42,162,000	$106,663,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$92,162,000	$213,326,000
STATE FUNDS	$42,162,000	$106,663,000
FEDERAL FUNDS	$50,000,000	$106,663,000

DESCRIPTION

Purpose:
This policy change estimates the funding for the Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) Out-of-Network Emergency Care Services Fund that was created to reimburse out-of-network hospitals for providing certain services to LIHP MCE enrollees.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
SB 920 (Hernandez, Statutes of 2012)
California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
SB 335 establishes the LIHP MCE Out-of-Network Emergency Care Services Fund, effective July 1, 2011 to December 31, 2013. Moneys shall be allocated from the fund by the Department to be matched with federal funds in accordance with the Special Terms and Conditions for the BTR. The Department shall disburse moneys from the fund to the LIHPs solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required post stabilization care provided by private hospitals that are outside the LIHP coverage network. SB 920 changes the amount transferred from the Hospital Quality Assurance Revenue Fund (HQARF) and subsequent payments. SB 920 further removes the non-designated public hospitals eligibility for this program.

Reason for Change from Prior Estimate:
The change is due to a shift in the availability of HQARF funds from FY 2014-15 to FY 2015-16.

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 89

Methodology:

1. IGT funds are to be used in their entirety before HQARF funds are used.

2. SB 920 authorizes HQARF funds to be transferred to LIHP MCE Out-of-Network Emergency Care Services Fund.

3. Current QAF collections and disbursements project that $106.7 million is available for transfer from the HQARF funds for FY 2011-12, FY 2012-13 and FY 2013-14.

4. LIHPs will provide utilization data for FY 2011-12, FY 2012-13, and FY 2013-14 to the Department after the fiscal year. The LIHP ended on December 31, 2013. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations.

5. The LIHP funds will be used to reimburse out-of-network hospitals.

6. IGTs will be deposited into and paid from the LIHP MCE Out-of-Network Emergency Care Services Fund.

(Dollars in Thousands)

FY 2014-15	TF	FFP	IGT	LIHP
FY 2011-12	$32,162	$20,000	$12,162	
FY 2012-13	$40,000	$20,000	$20,000	
FY 2013-14	$20,000	$10,000	$10,000	
Total FY 2014-15	**$92,162**	**$50,000**	**$42,162**	**$0**

FY 2015-16	TF	FFP	IGT	LIHP
FY 2011-12	$85,330	$42,665		$42,665
FY 2012-13	$85,330	$42,665		$42,665
FY 2013-14	$42,666	$21,333		$21,333
Total FY 2015-16	**$213,326**	**$106,663**	**$0**	**$106,663**

Funding:

Reimbursement Fund (4260-610-0995)
LIHP MCE OON Emergency Care Services Fund (4260-610-3201)
Title XIX FFP (4260-101-0890)

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	11/2010
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1572

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$87,064,000	$21,750,000
- STATE FUNDS	$1,907,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$87,064,000	$21,750,000
STATE FUNDS	$1,907,000	$0
FEDERAL FUNDS	$85,157,000	$21,750,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP, effective November 1, 2010 through December 31, 2013, consisted of two components, the Medicaid Coverage Expansion (MCE) and the HCCI (CI). The MCE covered eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those eligible individuals with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use two methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs)
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

The Department has used the CI cost claiming protocol for the MH/UCD as the basis for payments made on claims for dates of service from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and Conditions under the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 90

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. The CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013. The Department makes payments for dates of services beginning the second quarter of FY 2011-12 based on the new CPE cost claiming protocol.

The MCE program is not subject to a federal funding cap while HCCI funding is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13 and $180 million TC for DY 2013-14. Federal funding will be provided through the Health Care Support Fund (HCSF).

However, local spending under the HCCI has not reached $360 million. On June 28, 2013, the Department obtained CMS' approval of an amendment to the BTR Medicaid Demonstration waiver reallocating the unused HCCI funds for DY 2012-13 and DY 2013-14 to the SNCP uncompensated care component. The reallocation amounts are $97 million for DY 2012-13, and $26 million for DY 2013-14.

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

- Updated enrollment numbers for DY6 through DY 9, and
- DY 8 HCCI Rollover funds shifted from FY 2013-14 to FY 2014-15.

Methodology:

1. All remaining IGT-FQHC payments will be paid in FY 2014-15.

2. All CPE reconciliation payments for DY 6 through DY 9 will be paid in FY 2014-15 and FY 2015-16.

BTR - LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 90

3. The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2014-15	TF	IGT-FQHC	FFP
DY6: FY 2010-11	$2,975		$2,975
DY7: FY 2011-12	$4,107		$4,107
DY7: FY 2011-12	$3,814	$1,907	$1,907
DY8: FY 2012-13	$6,409		$6,409
DY8: FY 2012-13 (Rollover)	$48,500		$48,500
DY9: FY 2013-14	$8,259		$8,259
DY9: FY 2013-14 (Rollover)	$13,000		$13,000
Total FY 2014-15*	**$87,064**	**$1,907**	**$85,157**

FY 2015-16	TF	IGT-FQHC	FFP
DY6: FY 2010-11	$2,975		$2,975
DY7: FY 2011-12	$4,107		$4,107
DY8: FY 2012-13	$6,409		$6,409
DY9: FY 2013-14	$8,259		$8,259
Total FY 2015-16*	**$21,750**	**$0**	**$21,750**

*Total amounts may differ due to rounding.

Funding:
Health Care Support Fund (4260-601-7503)
Title XIX FFP (4260-101-0890)
LIHP IGT (4260-607-8502)

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER:	91
IMPLEMENTATION DATE:	10/2007
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1152

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$84,949,000	$326,815,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$84,949,000	$326,815,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$84,949,000	$326,815,000

DESCRIPTION

Purpose:
This policy change estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.4
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of MH/UCD and BTR, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 or 2552-10 cost report for the respective fiscal year. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, Medi-Cal administrative days, crossovers, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports.

MH/UCD & BTR—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 91

Reason for Change from Prior Estimate:
The DY 2006-07 final reconciliation amount for DPHs has decreased due to updated data. The DY 2007-08 final reconciliation has been moved to FY 2015-16 because the final reconciliation cannot be completed until all cost reports for FY 2007-08 have been audited and reviewed.

Methodology:
1. DPH's final reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the audited costs and the respective payments.

2. The final reconciliation for DY 2006-07 is expected to be completed by March 2015 and is estimated to be $84,949,000. Payments will be made in FY 2014-15.

3. The final reconciliation for DY 2007-08 is expected to be completed and paid by June 2016 and is estimated to be $326,815,000.

(Dollars in Thousands)

	FF
FY 2014-15	
2006-07 Final Reconciliation	**$84,949**
FY 2015-16	
2007-08 Final Reconciliation	**$326,815**

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

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER:	92
IMPLEMENTATION DATE:	5/2008
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1078

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$72,800,000	$80,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$72,800,000	$80,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$72,800,000	$80,000,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, pursuant to State Plan Amendment (SPA) 05-023, DPHs are to receive reimbursement based on certified public expenditures (CPEs) for their Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

SPA 05-023 that authorizes federal funding for this reimbursement was approved by the Centers for Medicare & Medicaid Services (CMS) in December 2007. CMS approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 92

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's physician and non-physician costs will be reconciled to the Medi-Cal cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

Reason for Change from Prior Estimate:
FY 2014-15 DPH projected payments have decreased due to updated payment data and the addition of FY 2006-07 final reconciliations.

Methodology:
1. In FY 2014-15 and FY 2015-16, one annual payment will be made for DPHs.

2. Reconciliation/final settlement of program year 2006-07 is anticipated to be completed during FY 2014-15 upon conclusion of the Physician/Non-Physician Practitioner time studies that are a required component of the reconciliation process.

3. The BTR will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

(Dollars in Thousands)	**Estimated Expenditures**	
FY 2014-15	**TF**	**FF**
DPH 2014-15	$80,000	$80,000
FY 2006-07 reconciliation	($7,200)	($7,200)
Total	**$72,800**	**$72,800**
FY 2015-16		
DPH 2015-16	**$80,000**	**$80,000**

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

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER:	93
IMPLEMENTATION DATE:	11/2010
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1571

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$14,534,000	$18,191,000
- STATE FUNDS	-$331,846,000	-$128,618,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$14,534,000	$18,191,000
STATE FUNDS	-$331,846,000	-$128,618,000
FEDERAL FUNDS	$346,380,000	$146,809,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
SB 208 (Chapter 71, Statutes 2009), Welfare & Institutions Code 14182.3
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
Interagency Agreement 10-87249 A 03
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 88 MH/UCD & BTR —CCS and GHPP
PC 103 MH/UCD & BTR —BCCTP
PC 105 MH/UCD & BTR —MIA-LTC

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Every Woman Counts (EWC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) · Song-Brown HealthCare Workforce Training · Steven M. Thompson Physician Corps Loan Repayment Program · Mental Health Loan Assumption Program University of California* California State University* California Community Colleges*
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

* CMS approval to include the University of California (UC), California State University (CSU) and California Community Colleges (CCCs) programs as DSHPs is still pending.

The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) for a five year total of $2 billion. This claiming has first priority on the Safety Net Care Pool (SNCP) funds. In addition to the above programs, AB 1467 allows the Designated Public Hospitals (DPHs) to voluntarily provide excess CPEs as necessary for the State to claim the full $400 million.

Reason for Change from Prior Estimate:
The change is due to:

- Delayed federal approval for the UC,CSU, and CCCs programs.
- Program expenditures were revised for DY 2014-15.
- Reserved SNCP Funds for DSHP claims have been updated based on revised program expenditures.
- Remaining DY 2013-14 ADAP claiming and ADAP reimbursement to CDPH were delayed to FY 2014-15.

Methodology:

1. The FFP for other departments is offset against State General Fund expenses in Item 4260-101-0001. Portions of the ADAP FFP, however, are offset against the CDPH budget. In FY 2014-15, of the $54,574,000 ADAP FFP available on an accrual basis, $6,219,000 is offset against the CDPH budget. In FY 2015-16, of the $18,191,000 ADAP FFP available on an accrual basis, $18,191,000 is offset against the CDPH budget. $8,315,000 budgeted to offset FY 2013-14 CDPH budget was reimbursed to CDPH in FY 2014-15.

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93

(Dollars in Thousands)
Cash Basis

FY 2014-15	**ADAP Reimbursement**
2013-14	$8,315
2014-15	$6,219
Total	**$14,534**
FY 2015-16	
2015-16	**$18,191**

2. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR —MIA-LTC and MH/UCD & BTR —BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR —CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

3. In prior years, the CPEs available from DSHP programs have not been sufficient to claim the $400 million FFP for each DY. AB 1467 permits the State to use DPH CPEs, as a condition for DPHs receiving Health Care Coverage Initiative rollover payments, to claim up to the $400 million limit. See “Reserved SNCP Funds for DSHP” in the table below.

4. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP will not continue in the subsequent waiver.

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93

The estimated BTR DSHP federal reimbursements are as follows:

(Dollars In Thousands)	Total DSHP (Accrual Basis)	Included in this PC (Cash Basis)	
	FFP	**FFP**	**FFP**
	DY 2014-15	**FY 2014-15**	**FY 2015-16**
CCS	$85,771		
GHPP	$66,533		
MIA-LTC	$25,508		
BCCTP	$2,415		
DHCS Total	$180,227		
ADAP	$72,765	$68,251	$18,191
Co. Mental Health	$52,551	$39,414	$13,137
DDS	$84,952	$63,714	$21,238
EWC	$0	$0	$0
PCTP	$1,209	$907	$302
OSHPD	$8,296	$6,222	$2,074
Univ. of Calif.	$0	$0	$0
CSU/Comm. Colleges	$0	$0	$0
CMSP	$0	$0	$0
Reserved SNCP Funds for DSHP	$0	$167,872	$91,867
Total Other Programs	$219,773	$346,380	$146,809
Grand Total	$400,000	**$346,380**	**$146,809**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER:	94
IMPLEMENTATION DATE:	7/2014
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1162

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$72,814,000	$114,741,000
- STATE FUNDS	$36,407,000	$57,370,500
PAYMENT LAG	0.6539	0.8738
% REFLECTED IN BASE	1.66 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$46,822,700	$100,260,700
STATE FUNDS	$23,411,350	$50,130,340
FEDERAL FUNDS	$23,411,350	$50,130,340

DESCRIPTION

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 104 MH/UCD & BTR — DPH Interim Rate

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the Selective Provider Contracting Program (SPCP) negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Reason for Change from Prior Estimate:
Based on actuals through July 2014, DPH expenditures were higher than previously projected for the period from February 2014 to July 2014. The base trend was adjusted for the updated expenditure data and resulted in an increased base estimate for FY 2014-15. In addition, the average interim rate increase in FY 2014-15 was 9% instead of 4.4%.

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 94

Methodology:

1. The DPHs received new FY 2014-15 interim rates as of July 1, 2014. These rates were based on FY 2012-13 costs trended to FY 2014-15.

2. Assume an average increase of 9% in the FY 2014-15 interim rates.

3. Assume a 4.8% increase in the FY 2015-16 interim rates.

4. An additional cost of $72,814,000 TF is estimated for FY 2014-15. The lagged cost on a cash basis is estimated to be approximately $46.82 million TF.

5. An additional cost of $114,741,000 TF is estimated for FY 2015-16. The lagged cost on a cash basis is estimated to be approximately $100.26 million TF.

6. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/50% FFP and are budgeted as 50% GF/50% FFP. The full adjustment is shown in the MH/UCD & BTR—DPH Interim Rate policy change.

Funding:

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

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	95
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1072

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$35,917,000	$10,835,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$35,917,000	$10,835,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$35,917,000	$10,835,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.7
MH/UCD

Interdependent Policy Changes:
Not Applicable

Background:
Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a SNCP was established to support the provision of services to the uninsured. The SNCP makes available $586 million in federal funds each of the five Demonstration Years (DYs) for baseline and stabilization funding and an additional $180 million per DY for implementing a healthcare coverage initiative during the last three years of the MH/UCD (Health Care Coverage Initiative). The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program (BCCTP). SNCP funding for the Health Care Coverage Initiative and for state-only programs are included in other policy changes.

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual $100,000,000 of the SNCP federal financial participation (FFP) for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 95

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs and SLAMSP, and drawn down by the state-funded programs cannot exceed $586 million.

SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503. Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

The reconciliation process for each DY may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

The MH/UCD was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the new BTR demonstration. A modified SNCP continues in the new demonstration; see policy change Bridge to Reform – Safety Net Care Pool.

Reason for Change from Prior Estimate:
The DY 2007-08 final reconciliation has been delayed to FY 2015-16 pending completion of the FY 2007-08 audited cost reports.

Methodology:
1. The final reconciliation for DY 2006-07 will be calculated and paid out in FY 2014-15.

2. The final reconciliation for DY 2007-08 will occur in FY 2015-16.

The estimated payments to the DPHs on a cash basis are:

(Dollars in Thousands)

Demonstration Year	FY 2014-15 FF	FY 2015-16 FF
2006-07	$35,917	$0
2007-08	$0	$10,835
Total	**$35,917**	**$10,835**

Funding:
100% Health Care Support Fund (4260-601-7503)

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER:	96
IMPLEMENTATION DATE:	7/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1698

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$30,750,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$30,750,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$30,750,000	$0

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of allocating unspent Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP) for Designated Public Hospitals (DPHs).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) are used to obtain the federal financial participation (FFP) for the LIHP-HCCI. Federal funding for the program is capped at $360 million total computable annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14. However, local spending under the HCCI has not reached $360 million. The Department has obtained approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent DY 2010-11, DY 2011-12, DY 2012-13, and DY 2013-14 HCCI money to the SNCP uncompensated care component. As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves the $400 million General Fund savings. See the BTR—Health Care Coverage Initiative Rollover Funds policy change for more information.

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 96

The funding reallocated to the SNCP will be shared 50/50 between the state and DPHs to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy change BTR—Increase Designated State Health Programs (DSHPs) for more information.

Reason for Change from Prior Estimate:
The change is due to the delay in finalizing the claiming methodology for DY 2012-13. DY 2012-13 was budgeted to be claimed in FY 2013-14 but will now be claimed in FY 2014-15.

Methodology:

1. The LIHP-HCCI total computable annual limit is $360 million for DYs 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14.

2. The Department projects LIHP-HCCI expenditures will be $184 million in DY 2010-11, $214 million in DY 2011-12, $263 million in DY 2012-13, and $154 million in DY 2013-14.

3. At a Federal Medical Assistance Percentage (FMAP) of 50%, $88 million FFP is available to rollover from DY 2010-11, $73 million FFP is available to rollover from DY 2011-12, $48.5 million FFP will be available to rollover from DY 2012-13, and $13 million FFP is available to rollover from DY 2013-14. Federal approval to rollover this funding for DY 2010-11 through DY 2013-14 has been obtained.

4. The LIHP program ended on December 31, 2013, therefore DY 2013-14 is the last year of the LIHP-HCCI rollover.

5. In FY 2014-15, assume the Department will claim LIHP-HCCI rollover funding available from DY 2012-13 and DY 2013-14 for a total of $61.5 million FFP.

6. Assume funds will be split 50/50 between the State and DPHs.

7. DPHs will receive $30.75 million in additional funding for uncompensated care costs in FY 2014-15.

(Dollars in Millions)

FY 2014-15	**FF**	**GF**
LIHP-HCCI Rollover		
DY 2012-13	($48.50)	$0.00
DY 2013-14	($13.00)	$0.00
Total	($61.50)	$0.00
Amount to SNCP-DPHs	**$30.75**	**$0.00**
Amount to General Fund	$30.75	($30.75)

Funding:
100% Health Care Support Fund (4260-601-7503)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 7/2006
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1153

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$19,500,000	$0
- STATE FUNDS	$19,500,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$19,500,000	$0
STATE FUNDS	$19,500,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.75
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration
AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:
Not Applicable

Background:
Stabilization funding is calculated as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between:
  a. The NDPHs' aggregate payment increase, and
  b. The sum of $0.544 million and 0.64% of total stabilization funding.

- Private Hospitals will receive total funds payment equal to the difference between:
  a. The Private Hospitals' aggregate payment increase, and
  b. The sum of $42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.

- Distressed Hospitals will receive total funds payments equal to the lesser of $23.5 million or 10% of total stabilization funding, with a minimum of $15.3 million.

- DPHs will receive General Fund (GF) payments to the extent that the state-funded programs certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 97

Stabilization for NDPHs and private hospitals is calculated; however, pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. This policy change budgets the stabilization payments available for DPHs and Distressed Hospitals payments.

Reason for Change from Prior Estimate:
The DY 2007-08 final reconciliation has been moved to FY 2015-16 because the final reconciliation cannot be completed until all cost reports for FY 2007-08 have been audited and reviewed. Budget year data is not included in this policy change because based on available data, the Department is estimating there will not be stabilization payments made to DPHs for DY 2007-08, and Distressed Hospital payments cannot be paid out until the distribution methodology is finalized.

Methodology:

1. Stabilization funding is calculated after the final reconciliation of the DPH interim payments is completed.

2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.

3. Stabilization funding to NDPHs, Private Hospitals, and Distressed Hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.

4. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Stabilization Funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the new BTR.

5. The MH/UCD final reconciliation calculation takes into account claiming for Designated State Health Programs as well as payments to DPHs and Distressed Hospitals. Additional stabilization payments may be made in FY 2015-16 in order to stay within the federal SNCP allotment of $586 million for DY 2005-06, this estimate is currently being finalized.

6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.

7. Final reconciliations will result in updated stabilization amounts for NDPH and Private Hospitals. These updated stabilization amounts will not be paid out.

8. Distressed Hospital payments are calculated as part of the MH/UCD waiver final reconciliation. These payments were previously distributed based on negotiations with the Office of the Selective Provider Contracting Program, formerly CMAC. The Department will now distribute these payments. Distressed Hospital payments for 2005-06 and 2006-07 were paid prior to FY 2013-14. Until the distribution methodology for Distressed Hospital payments in finalized, Distressed Hospital payments for DY 2007-08 through DY 2009-10 will not be paid out.

9. The DY 2006-07 final reconciliation for DPHs will be calculated in FY 2014-15 and paid in FY 2014-15.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 97

10. The DY 2007-08 final reconciliation for DPHs and Distressed Hospitals will be completed in FY 2014-15. It is assumed that the DPHs will have a net zero impact.

The estimated stabilization payments are:

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FF**
2006-07			
DPHs*	**$19,500**	**$19,500**	**$0**

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

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER:	98
IMPLEMENTATION DATE:	7/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1576

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$13,744,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$13,744,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$13,744,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Low Income Health Program (LIHP) payments for California Department of Corrections and Rehabilitation (CDCR) inmates receiving hospital inpatient services at hospitals off the grounds of the correctional facilities.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 92 (Chapter 36, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The BTR established the LIHP which was effective from November 1, 2010 through December 31, 2013. AB 1628 and SB 92 authorized the Department to claim federal funding for inpatient hospital services for certain inmates of CDCR correctional facilities. The eligible inpatient hospital services are services provided at hospitals that are off the grounds of the correctional facilities for inmates with family incomes at or below 133% of the Federal Poverty Level determined. The Department determines the eligible inmates for either the Medi-Cal program or the LIHP operated by the counties.

See Medi-Cal Adult Inmate Program policy change for the Medi-Cal covered costs.

CDCR/California Correctional Health Care Services (CCHCS) forwards the applications to the Department for the purpose of determining LIHP eligibility. CDCR/CCHCS pays the hospitals under contract for covered inpatient services and provides paid claims data to the individual county programs for certification and attestation of the Certified Public Expenditures (CPEs) and allowable inpatient hospital services for reimbursement of federal funding.

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 98

Reason for Change from Prior Estimate:
Payments previously scheduled to be made in FY 2013-14 are now scheduled to be made in FY 2014-15.

Methodology:

1. CDCR/CCHCS began to submit LIHP claims in March 2012.

2. The Department processes LIHP applications and assumes no additional county administrative costs.

3. 18 LIHPs will submit claims through FY 2013-14.
   - 19 LIHPs were implemented by March 2013.
   - One LIHP was implemented with an enrollment cap through December 31, 2013, and no claims will be submitted.
   - For two LIHPs, the date of services began on July 1, 2011.
   - For the remaining 16 LIHPs, the dates of services began on October 1, 2011.

4. Assume 246 average monthly approved LIHP inpatient stays.

   - Assume the Department will process 300 applications per month of which 80% will be LIHP inmate applications.
   - Assume 96% of processed LIHP inmate applications will be approved.
   - Assume there are 230 average monthly eligible LIHP inmates.
     300 total inmate applications processed x 80% LIHP x 96% approval rate = 230
   - Assume 7% of eligible LIHP inmates will receive two inpatient hospital services during a month.
     230 approved application x 7% = 16 additional monthly inpatient stays
   - 230 LIHP approved inmate applications + 16 additional monthly stays = 246

5. Assume 14 average monthly approved inpatient stays for each LIHP.
   - 246 total average monthly inpatient stays ÷ 18 LIHPs = 14

6. The annual LIHP inmate inpatient service costs are $62,877,600 TF.
   - The average cost per inpatient stay is estimated to be $21,300
   - 246 monthly approved inpatient stays x $21,300 average cost x 12 months = $62,877,600 TF

7. For FY 2011-12, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $50,097,600.

   - Effective July 1, 2011: 2 LIHPs x 14 approved applications x $21,300 average cost x 12 months = $7,156,800
   - Effective October 1, 2011: 16 LIHPs x 14 approved applications x $21,300 average cost x 9 months = $42,940,800

8. For FY 2012-13, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $62,877,600.

9. For FY 2013-14, the CPE on an accrual basis for LIHP inmate inpatient services costs is estimated to be $31,438,800.

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 98

10. The estimated federal fund for LIHP inmate inpatient service costs on an accrual basis:

(Dollars In Thousands)	TF	FF	CPE
FY 2011-12	$25,049	$25,049	$25,049
FY 2012-13	$31,439	$31,439	$31,439
FY 2013-14	$15,719	$15,719	$15,719

11. The Centers for Medicare and Medicaid Services (CMS) approved the claiming protocols in August 2012.

- The Department began processing payments for FY 2011-12 and FY 2012-13 in FY 2012-13.
- Remaining payments for FY 2011-12, FY 2012-13, and FY 2013-14 will be paid in FY 2014-15.

The estimated payments for inmate inpatient services on a cash basis:

(Dollars In Thousands)			
FY 2014-15	**TF**	**FF**	**CPE***
FY 2011-12	$1,284	$1,284	$1,284
FY 2012-13	$2,824	$2,824	$2,824
FY 2013-14	$9,637	$9,637	$9,637
Total**	**$13,744**	**$13,744**	$13,744

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

*Not included in Total Fund
**Amounts may differ due to rounding

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER:	99
IMPLEMENTATION DATE:	7/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1672

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$12,860,000	$0
- STATE FUNDS	$6,430,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,860,000	$0
STATE FUNDS	$6,430,000	$0
FEDERAL FUNDS	$6,430,000	$0

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Delivery System Reform Incentive Pool (DSRIP) Category 5 Human Immunodeficiency Virus (HIV) Transition Projects. Non-federal share of the payments are made through intergovernmental transfers (IGTs).

Authority:
SB 208 (Chapter 714, Statutes of 2010)
California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)
Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White)

Interdependent Policy Changes:
Not Applicable

Background:
As part of BTR, California counties implemented the Low Income Health Program (LIHP). The LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covers eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covers those with family incomes above 133% through 200% of the FPL.

The Department received program direction from the federal Health Resources and Services Administration (HRSA) and the Centers for Medicare & Medicaid Services (CMS) that according to the Ryan White HIV/AIDS Treatment Extension Act of 2009 “payer of last resort” requirements, Ryan White funded services can no longer be available to individuals living with HIV once they are determined eligible for and enrolled in a local LIHP. Therefore, these individuals who were previously covered under the Ryan White program will, upon enrollment in a local LIHP, be required to receive their medical care, pharmaceuticals, and mental health services under the LIHP.

The Department proposed an amendment to the Demonstration to CMS which authorizes the implementation of quality improvement projects within Designated Public Hospitals (DPHs). The DPHs support continuity of quality care, care coordination and other coverage transition issues concerning LIHP enrollees diagnosed with HIV, particularly those enrollees who previously received services under

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 99

the Ryan White program. CMS approved the amendment to the Demonstration on June 28, 2012.

The Department developed a DSRIP Category 5 HIV Transition Projects proposal (Proposal) which established the framework, performance measures, deliverables, and incentive payment structure for DSRIP Category 5 HIV Transition Projects. This Proposal was submitted to CMS on July 20, 2012, and it was approved on October 31, 2012. The Proposal served as the foundation for the development of two new supplements to the Special Terms and Conditions (STC Attachment P – Supplement 1 and Attachment Q – Supplement 1) authorized by the June 28, 2012 amendment to the Demonstration. On November 7, 2012, the Department submitted the proposed new supplements to CMS and they were approved on November 19, 2012.

The DSRIP Category 5 HIV Transition Projects were effective from July 1, 2012 through December 31, 2013. DPHs that implemented these approved projects receive incentive payments under the Safety Net Care Pool (SNCP) upon achievement of project milestones. According to the carry forward provisions of the STC, Attachment P – Supplement 1, the DPHs have until the end of the demonstration, October 31, 2015, to achieve the project milestones.

Reason for Change from Prior Estimate:
There are remaining funds available for this program since the full allocation was not taken in FY 2013-14.

Methodology:

1. During the term of the LIHP component of the Demonstration commencing with FY 2012-13, a total of $110 million in DSRIP Category 5 HIV Transition Project payments (total computable) was available annually.

2. $55 million (total computable) will be available for July 1 - December 31, 2013. The total available payments will be consistent with the Demonstration budget neutrality limit.

3. Of the $55 million, $12,860,000 is available to be claimed. This balance relates to the FY 2013-14 service year.

4. Total payment amounts will be allocated to each participating DPHs on the basis of its approved proposal. Payment amounts will be disbursed in semi-annual payments, if project milestones are achieved.

(Dollars in Thousands)	TF	IGT	FFP
FY 2014-15	$12,860	$6,430	$6,430
FY 2015-16	$0	$0	$0

Funding:
DSRIP IGT Fund (4260-601-3172)
Title XIX FFP (4260-101-0890)

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER:	100
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1076

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$4,708,000	$3,801,000
- STATE FUNDS	$2,354,000	$1,900,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,708,000	$3,801,000
STATE FUNDS	$2,354,000	$1,900,500
FEDERAL FUNDS	$2,354,000	$1,900,500

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.17
Medi-Cal Hospital/Uninsured Care Section 1115(a) Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
As part of the MH/UCD and the BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund, Item 4260-601-3096, using State General Fund (GF) and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers). Due to the inactivation of the Selective Provider Contracting Program (SPCP) for NDPHs on January 1, 2014; the Department will submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to continue the NDPH Supplemental Program and secure distributions from the NDPH Supplemental Fund for FY 2014-15.

Reason for Change from Prior Estimate:
The changes are due to an update to the FY 2013-14 balance and revised program expenditures.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 100

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated.

2. SB 1100 requires that $1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.

3. The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010.

4. The BTR will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

It is assumed NDPH supplemental payments will be made on a cash basis as follows:

	TF	SF	FF
FY 2014-15			
FY 2013-14 Ending Balance	$906,000	$453,000	$453,000
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
Est. FY 2013-14 Interest Earned	$2,000	$1,000	$1,000
Total Funds Available	$4,708,000	$2,354,000	$2,354,000
Cash Expenditures in FY 2014-15	**$4,708,000**	**$2,354,000**	**$2,354,000**
FY 2014-15 Ending Balance	$0	$0	$0
FY 2015-16			
FY 2014-15 Ending Balance	$0	$0	$0
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
Est. FY 2014-15 Interest Earned	$1,000	$500	$500
Total Funds Available	$3,801,000	$1,900,500	$1,900,500
Cash Expenditures in FY 2015-16	**$3,801,000**	**$1,900,500**	**$1,900,500**
FY 2015-16 Ending Balance	$0	$0	$0

Funding:

100% GF (4260-104-0001)
NDPH Supplemental Fund (less funded by GF) (4260-698-3096)
50% Title XIX / 50% NDPH Supplemental Fund (4260-601-3096/4260-101-0890)

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER:	101
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1769

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,756,000	$2,161,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,756,000	$2,161,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,756,000	$2,161,000

DESCRIPTION

Purpose:
This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) approved a waiver amendment to make uncompensated care payments through the Safety Net Care Pool (SNCP) – Uncompensated Care to IHS facilities.

Pursuant to the Special Terms and Conditions (STCs) of the BTR waiver, for the period covering April through December of 2013, IHS facilities may claim for services provided to uninsured individuals and optional benefits eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009).

On December 24, 2013, CMS approved the extension of IHS payments for the period covering January through December 2014. Under the extension, IHS facilities may claim for eliminated optional Medi-Cal benefits, but not for services provided to uninsured individuals.

Covered Services for Uninsured Individuals (April 5, 2013 to December 31, 2013)
Until December 31, 2013, IHS facilities were eligible to receive payments for the provision of California Medicaid State Plan primary care services and optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5 to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who were not enrolled in a Low Income Health Program (LIHP) or Medi-Cal, and
- have no source of third party coverage for the services they receive under this demonstration.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

Covered Services for Medi-Cal Enrollees
For Medi-Cal enrolled individuals, IHS facilities may receive payments for the provision of optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5.

FFP Claiming Methodology
Claims for allowable services will be paid at the IHS encounter rate. Claiming for Federal Financial Participation (FFP) will be based on certified public expenditures under this demonstration. For services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For the period covering April through December of 2013, services provided to non-IHS eligible individuals are also eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

Optional services eliminated from the State Plan include:

- Acupuncture
- Audiology
- Chiropractic
- Dental*
- Incontinence creams and washes
- Optician/optical lab
- Podiatry
- Psychology**
- Speech therapy

*AB 82 (Chapter 23, Statutes of 2013) restores certain adult dental benefits, effective May 1, 2014. The adult dental benefit restoration does not affect calendar year 2013. For calendar year 2014, eliminated dental services will be claimable for the time period from January 1, 2014 to April 30, 2014. Beginning May 1, 2014, some adult dental benefits were restored and will no longer be claimable under this program.

**SBX1 1 (Chapter 4, Statutes of 2013) restores psychology services, effective January 1, 2014.

Reason for Change from Prior Estimate:
Calendar Year 2013 increased due to unanticipated claims received and paid in July 2014. Calendar Year 2014 decreased due to lower estimated encounters and an update to the 2014 IHS global rate.

Methodology:

1. Additional claims for the period April 5, 2013 to December 31, 2013 in the amount of $595,000 were paid in July 2014.

Calendar Year 2014 Dates of Service Estimate:

2. The IHS global encounter rate for 2014 is $342 as per Federal Register #79 FR 19345.

3. Assume 120 encounters are related to optional benefits provided to IHS eligible Medi-Cal beneficiaries, not including dental and psychology services, in calendar year 2014.

4. Assume 6,200 encounters are due to dental services provided to IHS eligible Medi-Cal beneficiaries in calendar year 2014.

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 101

5. The estimated total payment for optional benefits for service dates from January 1, 2014 to December 31, 2014 is $2,161,000 FF.

   6,200 dental service encounters + 120 other optional benefit encounters = 6,320 encounters

   6,320 encounters x $342 = $2,161,000 FF (Rounded)

Calendar Year 2015 Dates of Service Estimate:

6. The BTR will end on October 31, 2015. The Department assumes the BTR funding will continue in the subsequent waiver.

7. Assume the Calendar Year 2015 (new waiver) encounters and rate will be the same as Calendar Year 2014.

	TF	FF
FY 2014-15		
Calendar Year 2013	$595,000	$595,000
Calendar Year 2014	$2,161,000	$2,161,000
Total	**$2,756,000**	**$2,756,000**
FY 2015-16		
Calendar Year 2015	**$2,161,000**	**$2,161,000**

Funding:

100% Health Care Support Fund (4260-601-7503)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 102
IMPLEMENTATION DATE: 9/2007
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1154

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$698,000	$3,539,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$698,000	$3,539,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$698,000	$3,539,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD).

Authority:
SB 1448 (Chapter 76, Statutes of 2006)
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds was available annually under the Safety Net Care Pool (SNCP) to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10. The funding for the HCCI was linked to the SNCP requirements reflected in the MH/UCD-Safety Net Care Pool policy change.

The federal funds available will reimburse the HCCI counties at an amount equal to the applicable Federal Medical Assistance Percentage of their Certified Public Expenditures (CPEs) for health care services provided to eligible low-income uninsured persons. The HCCI counties will submit their CPEs to the Department for verification and submission for federal financial participation (FFP).

The Demonstration, which would have ended on August 31, 2010, was extended until October 31, 2010. The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) became effective November 1, 2010. The federal funds for the extension period (September and October 2010) are provided through the new BTR funding for the first year of the BTR ending June 30, 2011. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 102

In FY 2014-15, reallocation of unspent funds and related reconciliation of payments will occur for DY 2008-09 and DY 2009-10. The payment reconciliations may result in additional FFP payments to or recovery of FFP payments from affected counties.

Reason for Change from Prior Estimate:
The change is due to:

- Updated information and payments that were processed, and
- A delay in final reconciliation.

Methodology:
1. Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	$ 8,204
Contra Costa County/Contra Costa Health Services	$ 15,250
County of Orange	$ 16,872
County of San Diego, Health and Human Services Agency	$ 13,040
County of Kern, Kern Medical Center	$ 10,000
Los Angeles County Department of Health Services	$ 54,000
San Francisco Department of Public Health	$ 24,370
San Mateo County	$ 7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	$ 20,700
Ventura County Health Care Agency	$ 10,000
Total	$180,000

2. Payments due to reallocation and related reconciliation for DY 2008-09 and DY 2009-10 under the MH/UCD HCCI are expected to be paid in FY 2014-15 and FY 2015-16.

The estimated HCCI payments on a cash basis are:

FY 2014-15	TF	FFP	CPE*
FY 2008-09	$698,000	$698,000	$698,000
FY 2009-10	$0	$0	$0
Total FY 2014-15	**$698,000**	**$698,000**	$698,000

FY 2015-16	TF	FFP	CPE*
FY 2008-09	$0	$0	$0
FY 2009-10	$3,539,000	$3,539,000	$3,539,000
Total FY 2015-15	**$3,539,000**	**$3,539,000**	$3,539,000

*Not included in TF.

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER:	103
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1084

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$1,980,000	-$655,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$1,980,000	-$655,000
FEDERAL FUNDS	$1,980,000	$655,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the State-Only Breast and Cervical Cancer Treatment Program (BCCTP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 93 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established by the MH/UCD.

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the BCCTP, effective January 1, 2002, for women under 200% of the federal poverty level (FPL). BCCTP is a State-Only program that covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Beneficiaries are screened through Centers for Disease Control (CDC) and Family Planning, Access, Care, and Treatment (Family PACT) providers.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The BCCTP is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 103

Reason for Change from Prior Estimate:
The DY 2010-11 final reconciliation was updated and delayed to FY 2014-15. In addition, DY 2014-15 program expenditures have been updated and claiming for DY 2014-15 will now occur in FY 2014-15 and FY 2015-16.

Methodology:

1. The FFP received for the BCCTP will be deposited in the Health Care Support Fund, Item 4260-601-7503.

2. The Department will claim for Demonstration Years (DY) 2010-11 and 2011-12 final reconciliations in FY 2014-15. The Department estimates claiming an additional $169,000 in FY 2014-15 for the DY 2010-11 and DY 2011-12 final reconciliations.

3. The final reconciliation for DY 2012-13 is anticipated to be completed in FY 2015-16. The Department estimates claiming an additional $51,000 in federal funds in FY 2015-16.

4. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP funding will not continue in the subsequent waiver.

The BCCTP federal reimbursements are:

	BCCTP
FY 2005-06	$1,182,000
FY 2006-07	$582,000
FY 2007-08	$0
FY 2008-09	$3,634,000
FY 2009-10	$2,137,000
FY 2010-11	$2,026,000
FY 2011-12	$1,509,000
FY 2012-13	$1,158,000
FY 2013-14	$1,915,000

FY 2014-15	**FF**
DSHP-BTR (DY 2014-15)	$1,811,000
DY 2010-11 Final Reconciliation	($95,000)
DY 2011-12 Final Reconciliation	$264,000
Total	**$1,980,000**

FY 2015-16	
DSHP-BTR (DY 2014-15)	$604,000
DY 2012-13 Final Reconciliation	$51,000
Total	**$655,000**

Funding:
100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER:	104
IMPLEMENTATION DATE:	7/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1161

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$427,930,500	-$450,468,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$427,930,500	-$450,468,500
FEDERAL FUNDS	$427,930,500	$450,468,500

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from 50% federal financial participation (FFP) to 100% FFP to reimburse Designated Public Hospitals (DPHs).

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 94 MH/UCD & BTR — DPH Interim Rate Growth

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs no longer receive the negotiated per diem rates under the Selective Provider Contracting Program (SPCP) for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Instead, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The previous SPCP negotiated per diem rates were paid with 50% FFP and 50% GF. Typically, the items in the Medi-Cal Estimate base trend are paid with 50% FFP and 50% GF. Since the DPH interim rate is paid with 100% FFP, an adjustment to shift from 50% GF to 100% FFP must be made in the base estimate data.

Reason for Change from Prior Estimate:
Based on actuals through July 2014, DPH expenditures were higher than previously projected for the period from February 2014 to July 2014. The base trend was adjusted for the updated expenditure data and resulted in an increased base estimate for FY 2014-15. In addition, the average interim rate increase in FY 2014-15 was 9% instead of 4.4%.

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 104

Methodology:

1. The funding adjustment is estimated at:

(Dollars in Thousands)	Expenditures	GF to FF shift
FY 2014-15	**$855,861**	**$427,930**
FY 2015-16	**$900,937**	**$450,468**

Funding:

50% Title XIX / 50% GF (4260-101-001/0890)
100% Title XIX FF (4260-101-0890)

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER:	105
IMPLEMENTATION DATE:	9/2005
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1079

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$21,161,000	-$5,152,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$21,161,000	-$5,152,000
FEDERAL FUNDS	$21,161,000	$5,152,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the Medically Indigent Adult Long-Term Care (MIA-LTC) program claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 93 BTR—Designated State Health Programs

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the MIA-LTC from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The MIA-LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The MIA-LTC program is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

Reason for Change from Prior Estimate:
The DY 2010-11 final reconciliation has been updated and delayed to FY 2014-15. In addition, DY 2014-15 program expenditures have been updated and claiming for DY 2014-15 will now occur in FY 2014-15 and FY 2015-16.

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 105

Methodology:

1. The FFP received for the MIA-LTC program will be deposited in the Health Care Support Fund, Item 4260-601-7503.

2. The Department will claim for Demonstration Years (DY) 2010-11 and 2011-12 final reconciliations in FY 2014-15. The Department estimates claiming an additional $2,030,000 in federal funds in FY 2014-15.

3. The final reconciliation for DY 2012-13 is anticipated to be completed in FY 2015-16. The Department estimates having to pay back the federal government $1,225,000 in federal funds in FY 2015-16.

4. The BTR will end on October 31, 2015. The Department assumes the BTR DSHP funding will not continue in the subsequent waiver.

The MIA-LTC federal reimbursements are:

	MIA LTC
FY 2005-06	$12,834,000
FY 2006-07	$18,375,000
FY 2007-08	$3,696,000
FY 2008-09	$18,980,000
FY 2009-10	$23,858,000
FY 2010-11	$26,939,000
FY 2011-12	$19,457,000
FY 2012-13	$19,661,000
FY 2013-14	$18,924,000

FY 2014-15	**FF**
DSHP-BTR (DY 2014-15)	$19,131,000
DY 2010-11 Final Reconciliation	$845,000
DY 2011-12 Final Reconciliation	$1,185,000
Total	**$21,161,000**
FY 2015-16	
DSHP-BTR (DY 2014-15)	$6,377,000
DY 2012-13 Final Reconciliation	($1,225,000)
Total	**$5,152,000**

Funding:

100% Health Care Support Fund (4260-601-7503)
100% GF (4260-101-0001)

BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1697

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$30,750,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$30,750,000	$0
FEDERAL FUNDS	$30,750,000	$0

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of allocating unspent Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP) for the Designated State Health Programs (DSHPs).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
Not Applicable

Background:
The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) are used to obtain the federal financial participation (FFP) for the LIHP-HCCI. Federal funding for the program is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14. However, local spending under the HCCI has not reached $360 million. The Department has obtained approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent DY 2010-11, DY 2011-12, DY 2012-13, and DY 2013-14 HCCI money to the SNCP uncompensated care component. As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves $400 million in annual General Fund savings. See the BTR—Health Care Coverage Initiative Rollover Funds policy change for more information.

BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 106

The funding reallocated to the SNCP will be shared 50/50 between the state and Designated Public Hospitals (DPHs) to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy change BTR—Increase Safety Net Care Pool for more information.

Reason for Change from Prior Estimate:
The change is due to the delay in finalizing the claiming methodology for DY 2012-13. DY 2012-13 was budgeted to be claimed in FY 2013-14 but will now be claimed in FY 2014-15.

Methodology:

1. The LIHP-HCCI total computable annual limit is $360 million for DYs 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14.

2. The Department projects LIHP-HCCI expenditures will be $184 million in DY 2010-11, $214 million in DY 2011-12, $263 million in DY 2012-13, and $154 million in DY 2013-14.

3. At a Federal Medical Assistance Percentage (FMAP) of 50%, $88 million FFP is available to rollover from DY 2010-11, $73 million FFP is available to rollover from DY 2011-12, $48.5 million FFP will be available to rollover from DY 2012-13, and $13 million FFP is available to rollover from DY 2013-14. Federal approval to rollover this funding for DY 2010-11 through DY 2013-14 has been obtained.

4. The LIHP program ended on December 31, 2013, therefore DY 2013-14 is the last year of the LIHP-HCCI rollover.

5. In FY 2014-15, assume the Department will claim LIHP-HCCI rollover funding available from DY 2012-13 and DY 2013-14 for a total of $61.5 million FFP.

6. Assume funds will be split 50/50 between the state and DPHs.

7. DPHs will receive $30.75 million in additional funding for uncompensated care costs in FY 2014-15. In addition, General Fund savings of $30.75 million are expected in FY 2014-15.

(Dollars in Millions)

FY 2014-15	**FF**	**GF**
LIHP-HCCI Rollover		
DY 2012-13	($48.50)	$0.00
DY 2013-14	($13.00)	$0.00
Total	($61.50)	$0.00
Amount to SNCP-DPHs	$30.75	$0.00
Amount to General Fund	**$30.75**	**($30.75)**

Funding:
100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 7/2010
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1459

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$19,724,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$19,724,000	$0
FEDERAL FUNDS	-$19,724,000	$0

DESCRIPTION

Purpose:
This policy change estimates the impact of the federal flexibilities policies which allows the claiming of unused Safety Net Care Pool (SNCP) federal funds to offset State General Fund expenditures.

Authority:
Welfare & Institutions Code 14166.221
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:
Not Applicable

Background:
Under the MH/UCD, $180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, $360 million of the funding was unused. On February 1, 2010, the Centers for Medicare & Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

Reason for Change from Prior Estimate:
Due to delayed mental health cost reports, the Demonstration Year (DY) 5 final reconciliation for the County Mental Health Services for the Uninsured (CMHS) program is no longer estimated to occur in FY 2014-15. In addition, the County Medical Services Program (CMSP) and AIDS Drug Assistance Program (ADAP) DY 5 final reconciliations that were to occur in FY 2013-14 are now expected to occur in FY 2014-15. The change in the CMSP and ADAP final reconciliation amounts is due to revised data.

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 107

Methodology:

1. The Department may claim these funds using the certified public expenditures from State-Only funded programs: Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).

2. AB 1653 (Chapter 218, Statutes of 2010) allowed the State to retain up to $420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. $135.083 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011.

4. The MH/UCD demonstration required settled and audited cost reports in order to complete the final reconciliation for CMHS. The claimable time period for DY 2009-10 (DY 5) for CMHS is February 2010 through August 2010. This spans five months in FY 2009-10 and two months in FY 2010-11. Final reconciliation of DY 2009-10 will be completed when FY 2009-10 and FY 2010-11 mental health cost reports are settled and audited.

5. The Department is not assuming completion of the CMHS reconciliations in FY 2015-16.

The General Fund costs/savings resulting from the federal flexibilities are expected to be:

(Dollars in Thousands)	TF	GF	FF	ARRA
FY 2014-15				
DY 5 CMSP Final Reconciliation	$0	($2,285)	$1,855	$430
DY 5 ADAP Final Reconciliation	$0	$22,009	($17,867)	($4,142)
Total	**$0**	**$19,724**	**($16,012)**	**($3,712)**

Funding:

100% GF (4260-101-0001)
100% Health Care Support Fund (4260-601-7503)

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1694

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$61,500,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$61,500,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$61,500,000	$0

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of allocating unspent Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP). These funding streams are available pursuant to the California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:
PC 90 BTR—Low Income Health Program - HCCI
PC 96 BTR—Increase Safety Net Care Pool
PC 106 BTR—Increase Designated State Health Programs

Background:
The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) are used to obtain the federal financial participation (FFP) for the LIHP-HCCI. Federal funding for the program is capped at $360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14. However, local spending under the HCCI has not reached $360 million. The Department has obtained approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent DY 2010-11, DY 2011-12, DY 2012-13, and DY 2013-14 HCCI money to the SNCP uncompensated care component. As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves $400 million in annual General Fund savings.

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 108

The funding reallocated to the SNCP will be shared 50/50 between the state and Designated Public Hospitals (DPHs) to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy changes BTR-Increase Safety Net Care Pool and BTR-Increase Designated State Health Programs (DSHPs) for more information.

Reason for Change from Prior Estimate:
The change is due to the delay in finalizing the claiming methodology for DY 2012-13. DY 2012-13 was budgeted to be claimed in FY 2013-14 but will now be claimed in FY 2014-15.

Methodology:

1. The LIHP-HCCI total computable annual limit is $360 million for DYs 2010-11, 2011-12, and 2012-13, and $180 million for DY 2013-14.

2. The Department projects LIHP-HCCI expenditures will be $184 million in DY 2010-11, $214 million in DY 2011-12, $263 million in DY 2012-13, and $154 million in DY 2013-14.

3. At a Federal Medical Assistance Percentage (FMAP) of 50%, $88 million FFP is available to rollover from DY 2010-11, $73 million FFP is available to rollover from DY 2011-12, $48.5 million FFP will be available to rollover from DY 2012-13, and $13 million FFP is available to rollover from DY 2013-14. Federal approval to rollover this funding for DY 2010-11 through DY 2013-14 has been obtained.

4. The LIHP program ended on December 31, 2013, therefore DY 2013-14 is the last year of the LIHP-HCCI rollover.

5. In FY 2014-15, assume the Department will claim LIHP-HCCI rollover funding available from DY 2012-13 and DY 2013-14 for a total of $61.5 million FFP.

6. Assume funds will be split 50/50 between the State and DPHs.

(Dollars in Millions)

FY 2014-15	**FF**	**GF**
LIHP-HCCI Rollover		
DY 2012-13	($48.50)	$0.00
DY 2013-14	($13.00)	$0.00
Total	**($61.50)**	**$0.00**
Amount to SNCP-DPHs	$30.75	$0.00
Amount to General Fund	$30.75	($30.75)

Funding:
100% Health Care Support Fund (4260-601-7503)

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER:	110
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1766

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$5,703,559,000	$11,265,739,000
- STATE FUNDS	$2,851,779,500	$5,632,869,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.97 %	3.53 %
APPLIED TO BASE		
TOTAL FUNDS	$5,191,949,800	$10,868,058,400
STATE FUNDS	$2,595,974,880	$5,434,029,210
FEDERAL FUNDS	$2,595,974,880	$5,434,029,210

DESCRIPTION

Purpose:
This policy changes estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioning from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
PC 113 CCI-Transfer of IHSS Costs to CDSS
PC 136 CCI-Savings and Deferral
PC 193 CCI-Transfer of IHSS Costs to DHCS
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. By enrolling these eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

The CCI will mandatorily enroll dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 110

Initially, the CCI will be implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Reason for Change from Prior Estimate:
The Department has delayed Orange to start August 2015 instead of January 2015 as previously assumed. Also, Alameda is no longer part of the CCI demonstration. Capitation rates for non-Cal MediConnect (CMC) and non-dual populations were updated.

Methodology:

1. Assume dual eligibles in the Medicare fee-for-service (FFS) program receiving LTC institutional and community-based services under the traditional FFS model will passively enroll into the CCI no later than January 1, 2015, except for Orange. Orange is scheduled to begin August 1, 2015. Depending on the county, eligibles will phase-in over 12 months or all at once.

2. Assume dual eligibles in Medicare Advantage (MA) plans that are also CMC plans will passively enroll into the CCI on January 1, 2015, except for Orange. Orange is scheduled to begin August 1, 2015. There is no phase-in assumed for this population.

3. Assume Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all excluded CMC dual eligibles (including non-CMC D-SNP) will have their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015, except for Orange. Orange is scheduled to begin August 1, 2015. Depending on the county and coverage type, eligibles may phase-in over 12 months or all at once.

4. In FY 2014-15, the Department estimates 1,182,211 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,182,211 average monthly beneficiaries, it is estimated 609,424 will be enrolled in a managed care plan. Of the 609,424 enrolled, 138,535 are dual eligibles who will passively enroll into CMC.

5. In FY 2015-16, the Department estimates 1,207,052 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,207,052 average monthly beneficiaries, it is estimated 1,147,238 will be enrolled in a managed care plan. Of the 1,147,238 enrolled, 268,629 are dual eligibles who will passively enroll into CMC.

6. Assume for participating dual eligibles, there will an overall average 1.14% savings in FY 2014-15 and 2.31% in FY 2015-16.

CCI-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 110

7. Estimated below is the overall impact of the CCI demonstration in FY 2014-15 and FY 2015-16.

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	**$5,703,559**	**$2,851,779**	**$2,851,779**	**$0**
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($3,349,416)	($1,674,708)	($1,674,708)	$0
Defer Managed Care Payment	($764,945)	($382,473)	($382,473)	$0
Total	($4,114,361)	($2,057,181)	($2,057,181)	$0
IHSS FFS Savings (In the Base)	($723,243)	$0	($723,243)	$0
Delay 1 Checkwrite (In the Base)	$73,488	$36,744	$36,744	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($723,243)	$0	$723,243
CCI-Transfer of IHSS Costs to CDSS (PC 113)	$1,497,113	$0	$0	$1,497,113
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$50,261	$25,131	$25,131	$0
Total of CCI PCs including pass through	$2,486,817	$133,231	$133,231	$2,220,355

(Dollars in Thousands) **FY 2015-16**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	**$11,265,739**	**$5,632,869**	**$5,632,869**	**$0**
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($7,948,284)	($3,974,142)	($3,974,142)	$0
Defer Managed Care Payment	($183,375)	($91,688)	($91,688)	$0
Total	($8,131,660)	($4,065,830)	($4,065,830)	$0
IHSS FFS Savings (In the Base)	($1,456,769)	$0	($1,456,769)	$0
Delay 1 Checkwrite (In the Base)	$34,490	$17,245	$17,245	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,456,769)	$0	$1,456,769
CCI-Transfer of IHSS Costs to CDSS (PC 113)	$3,015,512	$0	$0	$3,015,512
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$24,222	$12,111	$12,111	$0
Total of CCI PCs including pass through	$4,751,534	$139,626	$139,626	$4,472,281

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

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER:	113
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1653

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,497,113,000	$3,015,512,000
- STATE FUNDS	$1,497,113,000	$3,015,512,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,497,113,000	$3,015,512,000
STATE FUNDS	$1,497,113,000	$3,015,512,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to the California Department of Social Services (CDSS) for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles who receive LTC institutional services, IHSS, and other Home and Community-Based Services (HCBS) to managed care health plans beginning April 1, 2014.

The IHSS program provides an alternative to out-of-home care, such as nursing homes or board and care facilities. The transition and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS. It is assumed that the transition to managed care will increase the use of IHSS and other HCBS by 3.5%.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the CDSS pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population.

CCI-TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 113

This policy change addresses the transfer of IHSS costs from the managed care rates to the Department who will in turn transfer the funds to CDSS to pay the IHSS providers. The policy change, CCI-Transfer of IHSS Costs to DHCS, reflects the transfer of General Fund and county funds to the Department which is used to increase managed care capitation rates.

Reason for Change from Prior Estimate:
The Department has delayed Orange to start August 2015 instead of January 2015 as previously assumed. Also, Alameda is no longer part of the CCI demonstration. Additionally, non-dual capitated rates were updated and have a lower IHSS component within the rate.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2014-15 and FY 2015-16.

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	$5,703,559	$2,851,779	$2,851,779	$0
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($3,349,416)	($1,674,708)	($1,674,708)	$0
Defer Managed Care Payment	($764,945)	($382,473)	($382,473)	$0
Total	($4,114,361)	($2,057,181)	($2,057,181)	$0
IHSS FFS Savings (In the Base)	($723,243)	$0	($723,243)	$0
Delay 1 Checkwrite (In the Base)	$73,488	$36,744	$36,744	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($723,243)	$0	$723,243
CCI-Transfer of IHSS Costs to CDSS (PC 113)	**$1,497,113**	**$0**	**$0**	**$1,497,113**
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$50,261	$25,131	$25,131	$0
Total of CCI PCs including pass through	$2,486,817	$133,231	$133,231	$2,220,355

(Dollars in Thousands) **FY 2015-16**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	$11,265,739	$5,632,869	$5,632,869	$0
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($7,948,284)	($3,974,142)	($3,974,142)	$0
Defer Managed Care Payment	($183,375)	($91,688)	($91,688)	$0
Total	($8,131,660)	($4,065,830)	($4,065,830)	$0
IHSS FFS Savings (In the Base)	($1,456,769)	$0	($1,456,769)	$0
Delay 1 Checkwrite (In the Base)	$34,490	$17,245	$17,245	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,456,769)	$0	$1,456,769
CCI-Transfer of IHSS Costs to CDSS (PC 113)	**$3,015,512**	**$0**	**$0**	**$3,015,512**
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$24,222	$12,111	$12,111	$0
Total of CCI PCs including pass through	$4,751,534	$139,626	$139,626	$4,472,281

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

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER:	114
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1781

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,432,849,000	$1,909,157,000
- STATE FUNDS	$510,794,000	$705,708,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,432,849,000	$1,909,157,000
STATE FUNDS	$510,794,000	$705,708,500
FEDERAL FUNDS	$922,055,000	$1,203,448,500

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by Managed Care Organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The tax is effective July 1, 2013, through June 30, 2016.

The Administration proposes a new, broad-based tax that complies with federal law. The new proposal is intended to offset the same amount of General Fund expenditures as the current tax, as well as fund a restoration of the 7 percent reduction of IHSS hours required by a settlement agreement for two class-action lawsuits that challenged the reduction in IHSS hours: *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*.

Reason for Change from Prior Estimate:
New baseline rates have been developed for FY 2014-15 and placeholder rates for FY 2015-16.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 114

Methodology:

1. The MCO tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.

2. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

3. The premium revenue was multiplied by the MCO tax amount of 3.9375% to determine total tax revenue.

4. Capitation rate increases due to the MCO tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from Fund 3156 on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd Care Plans–Funding Adjustment policy change.

The costs of capitation rate increases related to the imposition of the MCO tax are expected to be:

(In Thousands)	TF	MCO Tax	FFP
FY 2014-15	**$1,432,849**	$510,794	$922,055
FY 2015-16	**$1,909,157**	$705,709	$1,203,448

Funding:

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

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER:	115
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1054

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,102,724,000	$864,408,000
- STATE FUNDS	$504,494,000	$395,465,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,102,724,000	$864,408,000
STATE FUNDS	$504,494,000	$395,465,000
FEDERAL FUNDS	$598,230,000	$468,943,000

DESCRIPTION

Purpose
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties or other approved public entities to the Department for the purpose of providing capitation rate increases to the managed care plans.

Authority:
Welfare & Institutions Code 14164 and 14301.4

Interdependent Policy Changes:
PC 129 Managed Care IGT Admin. And Processing Fee
PC 132 Extend Gross Premium Tax
PC 154 Extend Gross Premium Tax – Incr. Capitation Rates
PC 123 Extend Gross Premium Tax – Funding Adjustment
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Tax Mgd. Care Plans

Background:
An IGT is a transfer of funds from a public entity to the State. The non-federal share from the fund is matched with federal funds and used to make payments for capitation rate increases.

The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

The Department's rate range IGT program has grown significantly as more plans and providers have decided to participate. As Medi-Cal managed care significantly expands, the Department seeks to maintain the safety net and access to care by continuing and expanding plan and public providers' ability to leverage additional federal funding through the rate range IGT program.

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 115

Reason for Change from Prior Estimate:
The policy change was revised to incorporate updated IGTs.

Methodology:
COHS:
The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010. The IGT will continue on an ongoing basis.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; Merced and Sonoma Counties were effective retroactive to October 1, 2009; and Orange, Napa, and Yolo counties were effective retroactive to July 1, 2010. The IGTs for Marin, Mendocino, and Ventura Counties were effective retroactive to July 1, 2011. The IGTs will continue on an ongoing basis.

Two Plan Model:
An IGT for Los Angeles County was effective October 2006 and will continue on an ongoing basis.

IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara Counties were effective retroactive to October 1, 2008, and Fresno, Stanislaus, and Tulare Counties were effective retroactive to October 1, 2011. The IGTs will continue on an ongoing basis.

Geographic Managed Care:
The IGTs for Sacramento and San Diego Counties are effective retroactive to January 1, 2012. It is anticipated the IGTs will continue on an ongoing basis.

AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax (MCO Tax) of 2.35% on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. SB 78 (Chapter 33, Statutes of 2013) extended the gross premium tax through June 30, 2013. SB 78 also provides for a 3.9375% statewide tax on the total operating revenue of Medi-Cal Managed Care plans effective July 1, 2013, through June 30, 2016.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to General Fund policy change.

(Dollars in Thousands)

FY 2014-15

	IGT*	Regular FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	**$504,494**	**$455,660**	**$77,202**	**$65,368**	**$598,230**	**$1,102,724**

FY 2015-16

	IGT*	Regular FFP	T21 FFP	Family Planning FFP	Total FFP	TF
Total	**$395,465**	**$357,185**	**$60,517**	**$51,241**	**$468,943**	**$864,408**

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 115

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)
Reimbursement (4260-610-0995)*

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER:	117
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1588

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$384,834,000	$478,650,000
- STATE FUNDS	$192,417,000	$239,325,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$384,834,000	$478,650,000
STATE FUNDS	$192,417,000	$239,325,000
FEDERAL FUNDS	$192,417,000	$239,325,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases, as well as the related federal match portion of the capitation rate increases.

Authority:
SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:
PC 132 Extend Gross Premium Tax
PC 154 Extend Gross Premium Tax – Incr. Capitation Rates
PC 123 Extend Gross Premium Tax – Funding Adjustment
PC 129 Managed Care IGT Admin. & Processing Fee
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Since 2005, the inpatient care for fee-for-service (FFS) members receiving services at a DPH facility has been reimbursed under a cost-based payment and financing structure. The DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided. It is important to note that as a result of this funding arrangement, the State was not providing the state\local match requirement. Instead, the CPE process satisfied the state\local match requirement. Due to this payment structure, the transition of FFS SPDs to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while at the

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 117

same time ensuring that there are not new State GF expenditures. Other, non-inpatient services provided within the FFS structure by a DPH or its affiliated governmental entities (collectively, Public Providers) were being reimbursed through a combination of regulatory FFS rates, for which the nonfederal share was supported with State GF, and supplemental reimbursement above the FFS fee schedule, financed through the CPE mechanism, for the otherwise unreimbursed allowable costs of the services. The services for which these FFS supplemental reimbursement mechanisms apply include hospital outpatient, physician and non-physician practitioner professional, and non-hospital clinic services but does not include federally qualified health center (FQHC) services. These FFS payment structures no longer occur with respect to SPD beneficiaries that have transitioned to the managed care payment environment. Therefore, appropriate rate and other funding adjustments needed to be developed to reflect the historical patient reimbursement provided by these FFS methodologies in order to ensure access to services and adequate funding to these critical safety net providers.

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs. This portion is budgeted in the General Fund Reimbursements from DPHs Policy Change. In addition, the Public Providers will provide the non-federal share of the adjusted capitation related to the full recognition of the allowable costs (previously addressed by the FFS state plan reimbursement methodologies) for outpatient and other non-inpatient services through an IGT which is budgeted in this policy change.

Reason for Change from Prior Estimate:
Payments were delayed due to late approval by the Centers for Medicare and Medicaid Services (CMS). The placeholder for Year 4 payments was moved to 2015-16. In addition, the dollar amounts were adjusted to reflect the Year 1 overpayments, Year 2 IGT amounts and Year 3 scheduled payments.

Methodology:
Inpatient Hospital Services

1. Determine the baseline of DPH inpatient services/costs that are subject to transition into managed care.
2. Account for managed care factors applied in the capitation rate development process.
3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization which yields the calculated historical DPH allowable cost per day and related utilization.
4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rates for transitioned members.
5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members' baseline capitation rates. This portion is budgeted in the PC "General Fund Reimbursements from DPHs as stated above.
6. Calculate capitation rate adjustments.
7. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient rate adjustments.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 117

Non-Inpatient Services

1. Determine the baseline of Public Provider non-inpatient services/costs in FFS that are subject to transition into managed care and for which supplemental payments are available for Public Providers to draw down under FFS (excluding FQHC services).
2. Account for managed care factors applied in the capitation rate development process.
3. Calculate the expected Public Providers' non-inpatient cost per services for applicable SPDs for each applicable category of services.
4. Calculate the Public Provider utilization and costs that have already been built into the baseline managed care capitation rate for transitioning SPD members for the applicable categories of services.
5. Calculate the capitation rate adjustments for each applicable category of service.
6. Calculate the amount of funding (IGT) needed from Public Providers for the state/local match related to the non-inpatient rate adjustments.

Total Inpatient Hospital and Non-Inpatient Services

1. Add IGTs for Inpatient hospital services and non-inpatient services to determine total IGTs from DPHs.
2. The Department collects an estimated amount of the IGT in advance. Once the capitation payments have been made, the Department can determine the actual amount owed by the Health Plans. If there is an overage, the amount is applied toward the following year.
3. The initial (Year 1) IGTs include the period of July 1, 2011, through December 31, 2012, for the GMC model counties and July 1, 2011, through September 30, 2012, for the Two-Plan model counties. IGTs in the amount of $195,997,000 were received from the DPHs in FY 2012-13. Subsequent Two-Plan amended IGTs in the amount of $21,919,000 were received for Year 1 and $65,000 in DPH overpayments were applied against the Year 2 IGTs in FY 2013-14.
4. The Year 2 IGTs include the period of January 1, 2013, thorough December 21, 2013, for the GMC model counties, and October 1, 2012, through September 30, 2013, for the Two-Plan model counties. The IGTs in the amount of $199,855,000 were paid by the DPHs in FY 2013-14. Subsequently, Two-Plan amended IGTs in the estimated amount of $25,616,000 for Year 2 and $3,421,000 in DPH overpayments were identified and are scheduled to be applied against the Year 3 IGTs in FY 2014-15.
5. The Year 3 IGTs include the period January 1, 2014, through June 30, 2014, for the GMC model counties, and October 1, 2013, through June 30, 2014, for the Two-Plan model counties. The IGTs in the amount of $170,222,000 are scheduled to be paid by the DPHs in FY 2014-15.
6. The Year 4 IGTs include the period July 1, 2014, through June 30, 2015, for both the GMC model and Two-Plan model counties. The estimated IGTs have not yet been determined; therefore a placeholder in the amount of $239,325,000 is estimated for FY 2015-16.

(In Thousands)	IGT	FFP	TF
FY 2014-15			
Year 1 (overpayment)	($3,421)	($3,421)	($6,842)
Year 2	$25,616	$25,616	$51,232
Year 3	$170,222	$170,222	$340,444
Total	**$192,417**	**$192,417**	**$384,834**
FY 2015-16	**$239,325**	**$239,325**	**$478,650**

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 117

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

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER:	118
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1788

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$357,434,000	$0
- STATE FUNDS	$178,717,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$357,434,000	$0
STATE FUNDS	$178,717,000	$0
FEDERAL FUNDS	$178,717,000	$0

DESCRIPTION

Purpose:
This policy change estimates retroactive managed care capitation rate increases.

Authority:
Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:
PC 109 Two Plan Model
PC 111 County Organized Health Systems
PC 112 Geographic Managed Care
PC 154 Extend Gross Premium Tax – Incr. Capitation Rates
PC 123 Extend Gross Premium Tax – Funding Adjustment
PC 132 Extend Gross Premium Tax

Background:
Retroactive rate adjustments are due to the rate redeterminations for Fiscal Year 2013-14 for County Organized Health Systems (COHS). In addition, retroactive rate changes for Seniors and Persons with Disabilities (SPDs) impact rate periods from July 2011 through September 2013 for Two-Plan model plans and July 2011 through December 2013 for GMC plans. Capitation rate increases will be paid in FY 2014-15.

Reason for Change from Prior Estimate:
A delay in implementing payment system logic caused a mismatch of payments related to dual/partial dual members for the plans 2013-14 rate years through April 2014.

Methodology:

1. The Department determined the difference between what was calculated to be paid for FY 2013-14 and what was actually paid for FY 2013-14. This difference will be paid in FY 2014-15.

2. A comparison between rates paid for SPDs for July 2011 through September 2013 for Two Plan model plans and July 2011 through December 2013 for GMC plans was used to determine

RETRO MC RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 118

additional amounts for Fiscal Years 2011-12 and 2012-13 that will be paid in FY 2014-15.

3. The total estimated payments for FY 2014-15 also include the delays in implementing payment system logic related to dual/partial dual members for the plans 2013-14 rate years through April 2014.

(Dollars in Thousands)

FY 2014-15	2011-12 and 2012-13 Retro Rate Adjustments	2013-14 Retro Rate Adjustments	TF	GF	FF
Two Plan	$165,872	$69,327	$235,199	$117,600	$117,600
COHS	$0	$86,513	$86,513	$43,256	$43,257
GMC	$21,550	$14,172	$35,722	$17,861	$17,861
Total	$187,422	$170,012	**$357,434**	**$178,717**	**$178,718**

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

BLOOD FACTOR CARVE OUT

REGULAR POLICY CHANGE NUMBER:	122
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1878

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$37,200,000	$43,900,000
- STATE FUNDS	$18,600,000	$21,950,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$37,200,000	$43,900,000
STATE FUNDS	$18,600,000	$21,950,000
FEDERAL FUNDS	$18,600,000	$21,950,000

DESCRIPTION

Purpose:
This policy change estimates the cost of the blood factor carve-out.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Effective July 1, 2014, the blood factor pharmaceuticals used to treat hemophilia will no longer be covered within the managed care capitation rates. The services will instead be paid for in a fee-for service (FFS) capacity. The blood factor drug carve out will apply to Adult & Family (19 & Over), and Aged/Disabled Non-Duals. The programmatic change has been applied statewide and the impact will vary by Health Plan.

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

Methodology:
The following dollar amounts have been projected for the-carve out:

	FY 2014-15	FY 2015-16
Two-Plan	$10,100,000	$11,600,000
COHS	$21,300,000	$24,500,000
GMC	$1,800,000	$2,000,000
Regional	$4,000,000	$5,800,000
Total	**$37,200,000**	**$43,900,000**

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

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER:	123
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1652

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$23,288,000	$0
- STATE FUNDS	$11,644,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$23,288,000	$0
STATE FUNDS	$11,644,000	$0
FEDERAL FUNDS	$11,644,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by gross premium tax proceeds resulting from the extension of the gross premium tax. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 132 Extend Gross Premium Tax – Funding Adjustment
PC 131 Extend Gross Premium Tax

Background:
AB 1422 Imposed a Gross Premium Tax (GPT) on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue does not include amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The GPT imposed by AB 1422 was effective retroactively to January 1, 2009, through December 31, 2010. SB 853 extended the GPT through June 30, 2011. ABX1 21 extended the GPT through June 30, 2012. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period and will be matched with federal funds at the level in effect at that time.

SB 78 was signed by the Governor on June 27, 2013, and extended the gross premium tax through June 30, 2013, on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 123

beneficiaries. Due to a delay in approval, the FY 2012-13 payments are not expected to be paid until FY 2014-15.

The Managed Care Intergovernmental Transfer (IGT) provides for capitation rate increases to the managed care plans. Because a portion of the IGTs from prior periods won't occur until FY 2014-15, the GPT applies to these payments and will be reflected in FY 2014-15 costs.

Reason for Change from Prior Estimate:
Certain retro rate adjustments and IGTs were not paid as scheduled in FY 2013-14 and therefore will be paid in FY 2014-15. The policy change now includes the original Gross Premium Tax as well as the extensions of the Gross Premium Tax.

Methodology:

1. The gross premium tax proceeds are required to be used to increase the capitation rates due to the payments made to the State that result directly from the imposition of the gross premium tax.

2. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

3. Capitation rate increases due to the gross premium tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis. The reimbursement is budgeted in the Extend Gross Premium Tax – Funding Adjustment policy change.

The costs of capitation rate increases related to the extension of the gross premium tax sunset date are expected to be:

(Dollars in Thousands)

	TF	Gross Premium Tax	FFP
FY 2014-15	**$23,288**	$11,644	$11,644

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

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER:	124
IMPLEMENTATION DATE:	12/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1651

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$22,744,000	$1,472,000
- STATE FUNDS	$11,372,000	$736,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$22,744,000	$1,472,000
STATE FUNDS	$11,372,000	$736,000
FEDERAL FUNDS	$11,372,000	$736,000

DESCRIPTION

Purpose:
This policy change estimates the savings related to expanding managed care for Seniors and Persons with Disabilities (SPDs) into rural counties that were previously fee-for-service (FFS) only.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Managed care was previously in 30 counties. AB 1467 expanded managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

This expansion was implemented using two models, County Organized Health Systems (COHS) and a Regional Model, including San Benito and Imperial counties.

Reason for Change from Prior Estimate:
Rates, eligibles, and payment lags have been updated. Non-SPD and dual SPD populations in the Regional model counties have been transitioned into PC 116 Regional Model. This policy change now includes non-dual SPDs only.

Methodology:
1. The expansion occurred on November 1, 2013, for the Regional model, which includes the 20 counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba. SPD beneficiaries in all Regional counties have the option to enroll in managed care and it was assumed

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 124

less than 1% would enroll. It is expected that December 1, 2014, all non-dual SPDs will be required to enroll. Dual SPDs will retain the option to enroll, and it is assumed that less than 1% will remain enrolled. All other beneficiaries in the Regional counties were mandatorily enrolled on the implementation date.

2. Non-dual SPDs in San Benito County will remain voluntary, and it is assumed 30% will remain enrolled.

3. Assume that costs for the Regional expansions will be 99% of current FFS costs.

4. The expansion of managed care will result in a cost in FY 2013-14 on a cash basis because capitation payments begin immediately, while FFS payments continue for services provided before the expansion due to the time it takes providers to bill for services. The costs for FY 2014-15 and savings for FY 2015-16 are expected to be:

FY 2014-15	
Managed Care Capitation Payments	$168,011,000
Managed Care Deferral	($24,002,000)
FFS Savings	($169,708,000)
FFS Payment Lag	.7146
FFS Lagged Savings	($121,265,000)
FY 2014-15 Cost	**$22,744,000**
FY 2015-16	
Managed Care Capitation Payments	$298,302,000
FFS Savings	($301,315,000)
FFS Payment Lag	.9851
FFS Lagged Savings	($296,830,000)
FY 2015-16 Cost	**$1,472,000**

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

NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER:	126
IMPLEMENTATION DATE:	7/1998
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	95

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,000,000	$2,000,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,000,000	$2,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change includes funds for settlement agreements for disputes between the Department and managed care plans.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Various managed care plans have filed grievances or appeals challenging the rates the Department has established for the managed care programs. Every six months the Department develops an estimate of likely settlements for these disputes.

The Department attempts to claim federal funding, however, this policy change adjusts for settlements that are beyond the federal claiming deadline or include payments outside of the actuarially sound rate ranges. These settlements are budgeted at 100% General Fund.

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

Methodology:
Not Applicable

Funding:
100% General Fund (4260-101-0001)

CAPITATED RATE ADJUSTMENT FOR FY 2015-16

REGULAR POLICY CHANGE NUMBER: 128
IMPLEMENTATION DATE: 7/2015
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1338

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$581,653,000
- STATE FUNDS	$0	$281,211,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$581,653,000
STATE FUNDS	$0	$281,211,300
FEDERAL FUNDS	$0	$300,441,700

DESCRIPTION

Purpose:
The policy change estimates the increase for the Managed Care capitation rates for fiscal year (FY) 2015-16.

Authority:
Not Applicable

Interdependent Policy Changes:
PC 109 Two Plan Model
PC 111 County Organized Health Systems
PC 112 Geographic Managed Care
PC 125 AIDS Healthcare Centers (Other M/C)
PC 127 Family Mosaic Capitated Case Mgmt. (Other M/C)
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Managed care capitation rates will be rebased in FY 2015-16 as determined by the rate methodology based on more recent data. Adjustments will be implemented based on the rate year of the managed care model types.

This policy change budgets a placeholder increase of 3.57% for the FY 2015-16 rates based on the FY 2013-14 to FY 2014-15 overall rate increases. Actual managed care rate adjustments for FY 2015-16 will be available for the May 2015 estimate.

Reason for Change from Prior Estimate:
Updated rates and eligibles have been incorporated into the Base PCs. The projected dollars were calculated using an updated rate adjustment.

CAPITATED RATE ADJUSTMENT FOR FY 2015-16

REGULAR POLICY CHANGE NUMBER: 128

Methodology:

(Rounded)	Cost by Plan	Rate Adjustment	Rate Increase
Two Plan	$9,425,937,000	3.57%	**$336,506,000**
COHS	$4,652,444,000	3.57%	**$166,092,000**
GMC	$1,819,186,000	3.57%	**$64,945,000**
Regional	$7,003,000	3.57%	**$250,000**
AHF	$388,228,000	3.57%	**$13,860,000**
Total	$16,292,798,000	3.57%	**$581,653,000**

Funding:

(Dollars in Thousands)

	Two Plan	COHS	GMC	Regional	AHF	Total
Title XIX 50/50 FFP 4260-101-0001/0890	$306,671	$152,008	$59,116	$11,837	$250	**$529,882**
State GF 4260-101-0001	$676	$176	$105	$39	$0	**$996**
Family Planning 90/10 GF 4260-101-0001/0890	$7,447	$1,454	$805	$283	$0	**$9,989**
Healthy Families 65/35 GF 4260-101-0001/0890	$21,712	$12,454	$4,918	$1,700	$0	**$40,784**
Total FFP	$174,151	$85,408	$33,479	$7,278	$125	**$300,441**
Total GF	$162,355	$80,684	$31,465	$6,581	$125	**$281,210**
Total (Rounded)	**$336,506**	**$166,092**	**$64,944**	**$13,859**	**$250**	**$581,651**

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER:	129
IMPLEMENTATION DATE:	7/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1601

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose
This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities.

Authority:
AB 102 (Chapter 29, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
The counties or other approved public entities transfer funds as IGTs to the Department to provide capitation rate increases to the managed care plans. These funds provide the nonfederal share of capitation rate increases, which are budgeted in the Managed Care Rate Range IGT policy change. The Department develops an actuarially sound rate range that consists of a lower and upper bound rate. The state has the option of paying plans any rate that is within the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Per AB 102, beginning July 1, 2011, the Department began charging counties or other approved public entities a 20% administrative and processing fee for their IGTs. These fees are not charged for certain IGTs related to designated public hospitals and IGTs authorized pursuant to Welfare & Institutions Code Sections 14168.7 and 14182.15.

Reason for Change from Prior Period:
The policy change was revised to incorporate updated IGT amounts.

Methodology:
1. The fee will be 20% of each IGT.

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 129

2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.

(Dollars In Thousands)	IGT amount subject to the fee	20% Admin. & Processing Fee		Support Cost Reimbursement to GF		Local Assistance Reimbursement to GF
FY 2014-15	$ 455,516	$ 91,103	-	$ 251	=	**$ 90,852**
FY 2015-16	$ 366,727	$ 73,345	-	$ 251	=	**$ 73,094**

Funding:
100% State GF (4260-101-0001)
Reimbursement (4260-610-0995)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER:	130
IMPLEMENTATION DATE:	5/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1605

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will reimburse the General Fund (GF) for the costs built into the managed care baseline capitation rates.

Authority:
SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
Effective June 1, 2011, SPDs who were not covered under other health care coverage were assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care (GMC) model counties. As of May 2012, all mandatory enrollees had been fully transitioned into managed care.

Since 2005, the inpatient care for fee-for-service (FFS) members receiving services at a DPH facility has been reimbursed under a cost-based payment and financing structure. The DPHs used a certified public expenditure (CPE) methodology to draw down and receive the federal share of the allowable costs associated with the inpatient services provided. It is important to note that as a result of this funding arrangement, the State was not providing the state\local match requirement. Instead, the CPE process satisfied the state\local match requirement. Due to this payment structure, the transition of FFS Seniors and Persons with Disabilities (SPDs) to managed care created a need for a solution that would permit a DPH to continue to receive net per service reimbursement for inpatient services at levels comparable to FFS, while at the same time ensuring that there are not new State GF expenditures. Other, non-inpatient services provided within the FFS structure by a DPH or its affiliated governmental entities (collectively, Public Providers) were being reimbursed through a combination of regulatory FFS rates, for which the nonfederal share was supported with State GF, and supplemental reimbursement above the FFS fee schedule, financed through the CPE mechanism, for the otherwise unreimbursed allowable costs of the services. The services for which these FFS supplemental

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 130

reimbursement mechanisms apply include hospital outpatient, physician and non-physician practitioner professional, and non-hospital clinic services but does not include federally qualified health center (FQHC) services. These FFS payment structures no longer occur with respect to SPD beneficiaries that have transitioned to the managed care payment environment. Therefore, appropriate rate and other funding adjustments needed to be developed to reflect the historical patient reimbursement provided by these FFS methodologies in order to ensure access to services and adequate funding to these critical safety net providers.

The payment structure for the previously FFS SPD members transitioning into managed care called for adjustments to be made to the baseline SPD capitation rates so that the historical Public Provider allowable costs for services are also recognized and included in the managed care capitated rates. Public Providers will provide the non-federal share of the portion of the adjustment capitation related to allowable costs of their inpatient services through an IGT. A portion of the IGT related to inpatient services will fund a portion of the unadjusted baseline capitation rates for the newly enrolled SPDs.

In FY 2012-13, the DPHs began reimbursing the GF through an IGT for costs that are built into the managed care baseline capitation rates that would not have been incurred had the SPDs remained in FFS.

Reason for Change from Prior Estimate:
Due to a delay in the CMS approval process, Year 4 Payments will be made in FY 2015-16.

Methodology:

1. Determine the baseline of DPH inpatient services/costs in FFS that are subject to transition into managed care.

2. Account for managed care factors applied in the capitation rate development process.

3. Calculate the expected DPH inpatient cost per day for applicable SPDs. Divide the total costs by the total utilization, which yields the calculated historical DPH allowable cost per day and related utilization.

4. Calculate the DPH utilization and costs that have already been built into the baseline managed care capitation rate for transitioned members.

5. Calculate the amount of funding (IGT) needed from DPHs for the state/local match related to the inpatient portion of services included in the transitioned SPD members' baseline capitation rates.

6. The initial (Year 1) GF reimbursement includes the period of July 1, 2011, through December 31, 2012, for the GMC model counties, and July 1, 2011, through September 30, 2012, for the Two-Plan model counties. A reimbursement in the amount of $86,912,000 was made in FY 2012-13. Subsequently, $65,000 in DPH overpayments were applied against the Year 2 reimbursement.

7. The Year 2 reimbursement includes the period of January 1, 2013, through December 31, 2013, for the GMC model counties, and October 1, 2012, through September 30, 2013, for the Two-Plan model counties. A reimbursement in the amount of $80,436,000 was made in FY 2013-14. Subsequently, $3,421,000 in DPH overpayments were identified and are scheduled to be applied against the Year 3 reimbursement.

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 130

8. The Year 3 reimbursement includes the period January 1, 2014, through June 30, 2014, for the GMC model counties, and October 1, 2013, through June 30, 2014, for the Two-Plan model counties. A reimbursement in the amount of $61,842,000 is scheduled to be made in FY 2014-15.

9. The Year 4 reimbursement will include the period of July 1, 2014, through June 30, 2015, for both the GMC and the Two-Plan model counties. The reimbursement has not yet been calculated; therefore, a placeholder in the amount of $89,348,000 is estimated for FY 2015-16.

	FY 2014-15	FY 2015-16
Year 2 Reimbursement from DPHs	($ 3,421,000)	$ 0
Year 3 Reimbursement from DPHs	$ 61,842,000	$ 0
Year 4 Reimbursement from DPHs	$ 0	$ 89,348,000
Total Reimbursement	$ 58,421,000	$ 89,348,000
GF	($ 58,421,000)	($ 89,348,000)
Net Impact	**$ 0**	**$ 0**

Funding:
Reimbursement (4260-610-0995)
100% State GF (4260-101-1001)

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER:	131
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1647

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the Gross Premium Tax Fund to the General Fund (GF) to be retained by the Department.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and extends the gross premium tax sunset date that through June 30, 2013. Prior to October 1, 2012 transition of the Healthy Families Program to Medi-Cal, the portion of the gross premium tax shown in this policy change was used to fund the Healthy Families Program. Beginning October 1, 2012, this portion of the tax will be retained by the Department to offset GF cost for the Medi-Cal program. This policy change estimates GF savings resulting from the extension of the gross premium tax sunset date through June 30, 2013. Due to a delay in approval, the FY 2012-13 payments are not expected to be made until FY 2014-15.

Reason for Change from Prior Estimate:
The most recent estimates of managed care revenues have been used to estimate the gross premium tax amount.

Methodology:
1. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. The FY 2012-13 impact of the increase in capitation payments related to the gross premium tax is included in the Extend Gross Premium Tax – Incr. Capitation Rates policy change.

3. The total available Gross Premium Tax revenue in FY 2014-15 is estimated to be $11,644,000.

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 131

The gross premium tax fund transfers to the GF are expected to be:

FY 2014-15	TF	GF	Gross Premium Tax
Total	**$0**	($11,644,000)	$11,644,000

Funding:
100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	132
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1655

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds from the Gross Premium Tax Fund to the General Fund as a result of a proposal to extend the Gross Premium Tax.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
SB 78 was signed by the Governor on June 27, 2013, and extended the collection of a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2013. The proceeds from the tax are used to offset capitation rates. Due to a delay in approval, the FY 2012-13 transfer is not expected to occur until FY 2014-15.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis.

Reason for Change from Prior Estimate:
The most recent estimates of gross premium tax revenues have been used to estimate the funding adjustment.

Methodology:
1. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

2. Assume that transfers from the Department of Insurance take place three months after quarterly tax payments.

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 132

The gross premium tax fund transfers to the GF are expected to be:

	TF	GF	Gross Premium Tax
FY 2014-15	**$0**	$ (11,644,000)	$ 11,644,000

Funding:
100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	7/2005
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1082

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change is for informational purposes only.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
This policy change specifies the cost of services that are in addition to the managed care capitation rates. FFS expenditures occur for managed care enrollees for covered Medi-Cal services excluded by the health plan contract.

Reason for Change from Prior Estimate:
Updated FFS payment information.

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 133

Methodology:
In Fiscal Year 2014-2015 FFS payments for managed care enrollees totaled:

	Expenditures by Aid Category		
	Other	**CCS/GHPP**	**Total**
Families	$719,495,000	$879,716,000	$1,599,211,000
Disabled	$887,700,000	$941,275,000	$1,828,975,000
Aged	-$10,393,000	$2,000	-$10,391,000
200% Poverty	$216,000	$49,027,000	$49,243,000
MI Child	$7,816,000	$24,414,000	$32,230,000
133% Poverty	$21,436,000	$18,376,000	$39,812,000
Other	-$842,000	$57,000	-$785,000
100% Poverty	$27,622,000	$45,627,000	$73,249,000
Blind	$13,930,000	$24,919,000	$38,849,000
MI Adult	$2,282,000	$390,000	$2,672,000
Totals	**$1,669,262,000**	**$1,983,803,000**	**$3,653,065,000**

Funding:
Not Applicable

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1782

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 135 MCO Tax Managed Care Plans

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be retained by the Department to offset GF cost for capitated rate increases as a result of the imposition of the tax. This policy change estimates the offset of GF costs for the capitated rate increases.

The Administration proposes a new, broad-based tax that complies with federal law. The new proposal is intended to offset the same amount of General Fund expenditures as the current tax, as well as fund a restoration of the 7 percent reduction of IHSS hours required by a settlement agreement for two class-action lawsuits that challenged the reduction in IHSS hours: *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*.

Reason for Change from Prior Estimate:
New baseline rates have been developed for FY 2014-15 and placeholder rates for FY 2015-16.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 134

Methodology:

1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans– Incr. Cap. Rates policy change.

The MCO tax fund transfers to the GF are expected to be:

	TF	GF	MCO Tax
FY 2014-15	**$0**	**($465,894,000)**	**$465,894,000**
FY 2015-16	**$0**	**($656,980,000)**	**$656,980,000**

Funding:

100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1783

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2013.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be continuously appropriated to the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates GF savings resulting from the imposition of the MCO tax.

The Administration proposes a new, broad-based tax that complies with federal law. The new proposal is intended to offset the same amount of General Fund expenditures as the current tax, as well as fund a restoration of the 7 percent reduction of IHSS hours required by a settlement agreement for two class-action lawsuits that challenged the reduction in IHSS hours: *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger.*

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 135

Reason for Change from Prior Estimate:
New baseline rates have been developed for FY 2014-15 and placeholder rates for FY 2015-16. Also, GF savings previously in the ACA Optional and Mandatory Expansion policy changes are now included here.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

The MCO tax fund transfers to the GF are expected to be:

	TF	GF	MCO Tax
FY 2014-15	**$0**	**($802,798,000)**	**$802,798,000**
FY 2015-16	**$0**	**($1,133,100,000)**	**$1,133,100,000**

Funding:
100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER:	136
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1641

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$4,114,361,000	-$8,131,660,000
- STATE FUNDS	-$2,057,180,500	-$4,065,830,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.97 %	3.53 %
APPLIED TO BASE		
TOTAL FUNDS	-$3,745,302,800	-$7,844,612,400
STATE FUNDS	-$1,872,651,410	-$3,922,306,200
FEDERAL FUNDS	-$1,872,651,410	-$3,922,306,200

DESCRIPTION

Purpose:
This policy change estimates the savings from transitioning dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries from fee-for-service (FFS) into Medi-Cal managed care health plans for their Medi-Cal Long-Term Care (LTC) institutional and community-based services and supports benefits.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
PC 113 CCI-Transfer of IHSS Costs to CDSS
PC 110 CCI-Managed Care Payments
PC 193 CCI-Transfer of IHSS Costs to DHCS
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. By enrolling these eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

The CCI will mandatorily enroll dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services.

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER: 136

Initially, the CCI will be implemented in seven pilot counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The transitions and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS.

Reason for Change from Prior Estimate:
The Department has delayed Orange to start August 2015 instead of January 2015 as previously assumed. Also, Alameda is no longer part of the CCI demonstration.

Methodology:

1. Assume dual eligibles in the Medicare fee-for-service (FFS) program receiving LTC institutional and community-based services under the traditional FFS model will passively enroll into the CCI no later than January 1, 2015, except for Orange. Orange is scheduled to begin August 1, 2015. Depending on the county, eligibles will phase-in over 12 months or all at once.

2. Assume dual eligibles in Medicare Advantage (MA) plans that are also CMC plans will passively enroll into the CCI on January 1, 2015, except for Orange. Orange is scheduled to begin August 1, 2015. There is no phase-in assumed for this population.

3. Assume Medi-Cal only eligibles, individuals receiving partial Medicare coverage, and all excluded CMC dual eligibles (including non-CMC D-SNP) will have their LTC and community-based services included in Medi-Cal managed care no later than January 1, 2015, except for Orange. Orange is scheduled to begin August 1, 2015. Depending on the county and coverage type, eligibles may phase-in over 12 months or all at once.

4. In FY 2014-15, the Department estimates 1,182,211 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,182,211 average monthly beneficiaries, it is estimated 609,424 will be enrolled in a managed care plan. Of the 609,424 enrolled, 138,535 are dual eligibles who will passively enroll into CMC.

5. In FY 2015-16, the Department estimates 1,207,052 average monthly beneficiaries will be eligible for a managed care plan in the seven pilot counties. Of the 1,207,052 average monthly beneficiaries, it is estimated 1,147,238 will be enrolled in a managed care plan. Of the 1,147,238 enrolled, 268,629 are dual eligibles who will passively enroll into CMC.

6. Assume for participating dual eligibles, there will an overall average 1.14% savings in FY 2014-15 and 2.31% in FY 2015-16.

CCI-SAVINGS AND DEFERRAL

REGULAR POLICY CHANGE NUMBER: 136

7. Estimated below is the overall impact of the CCI demonstration in FY 2014-15 and FY 2015-16.

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	$5,703,559	$2,851,779	$2,851,779	$0
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($3,349,416)	($1,674,708)	($1,674,708)	$0
Defer Managed Care Payment	($764,945)	($382,473)	($382,473)	$0
Total	**($4,114,361)**	**($2,057,181)**	**($2,057,181)**	**$0**
IHSS FFS Savings (In the Base)	($723,243)	$0	($723,243)	$0
Delay 1 Checkwrite (In the Base)	$73,488	$36,744	$36,744	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($723,243)	$0	$723,243
CCI-Transfer of IHSS Costs to CDSS (PC 113)	$1,497,113	$0	$0	$1,497,113
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$50,261	$25,131	$25,131	$0
Total of CCI PCs including pass through	$2,486,817	$133,231	$133,231	$2,220,355

(Dollars in Thousands) **FY 2015-16**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	$11,265,739	$5,632,869	$5,632,869	$0
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($7,948,284)	($3,974,142)	($3,974,142)	$0
Defer Managed Care Payment	($183,375)	($91,688)	($91,688)	$0
Total	**($8,131,660)**	**($4,065,830)**	**($4,065,830)**	**$0**
IHSS FFS Savings (In the Base)	($1,456,769)	$0	($1,456,769)	$0
Delay 1 Checkwrite (In the Base)	$34,490	$17,245	$17,245	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	$0	($1,456,769)	$0	$1,456,769
CCI-Transfer of IHSS Costs to CDSS (PC 113)	$3,015,512	$0	$0	$3,015,512
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$24,222	$12,111	$12,111	$0
Total of CCI PCs including pass through	$4,751,534	$139,626	$139,626	$4,472,281

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

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER:	137
IMPLEMENTATION DATE:	7/2008
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1329

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$236,248,000	$263,824,000
- STATE FUNDS	$118,124,000	$131,912,000
PAYMENT LAG	0.9835	0.9861
% REFLECTED IN BASE	1.37 %	1.25 %
APPLIED TO BASE		
TOTAL FUNDS	$229,166,700	$256,904,900
STATE FUNDS	$114,583,360	$128,452,440
FEDERAL FUNDS	$114,583,360	$128,452,440

DESCRIPTION

Purpose:
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) according to the Prospective Payment System (PPS). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (CBRCs) after a reconciliation audit has been completed.

Authority:
Welfare & Institutions Code, section 14170

Interdependent Policy Changes:
Not Applicable

Background:
For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, an interim rate is established and paid to the clinics. Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, managed care plans, and Medicare) in order to prepare a final settlement with the clinic.

CBRCs, owned or operated by Los Angeles County, are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The FY 2009-10 audited levels will be used to update the CBRC rates as of July 1, 2014. The Department is scheduled to complete the CBRC reconciliation audit for FY 2010-11 in FY 2014-15 and will complete FY 2011-12 in FY 2015-16. Interim rates will be adjusted to the FY 2010-11 audited levels beginning in FY 2014-15, and to the FY 2011-12 audited levels in FY 2015-16.

Currently, there are 891 active FQHCs, 344 active RHCs and 29 active CBRCs.

Reason for Change from Prior Estimate:
LA CBRC rate increases were adjusted for FYs 2014-15 and 2015-16.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 137

Methodology:

1. The estimated FQHC/RHC's reconciliation for each fiscal year respectively is based on a three year average of the reported settlement amount versus actual settlement.

2. The estimated FQHC retroactive rate adjustment of $52,692,000 for FY 2014-15 and $62,333,000 for FY 2015-16 is based on a three year average of the previous year's EPC's that have been implemented and paid.

3. The FY 2014-15 LA CBRC reconciliation is based on the settlement of 91.2% of 2010 reported settlements, while the FY 2015-16 reconciliation is based on settlement of 95% of the 2011 reported settlements. Based on reported costs for fiscal years 2007-2013, reconciliations are expected to increase by 5.13% thereafter.

   Hospital closures and/or ancillary facilities no longer utilizing the hospitals' PPS rate may have attributed to the LA CBRC reconciliation decrease between FY 2014-15 and FY 2015-16.

4. The July 1, 2014 CBRC rate increase of $24,420,000 is based on the 2010 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2012-13. The estimated payment increase is determined by the difference between the calculated estimated payment and the total payments per the Paid Claims Summary Reports for FY 2012-13.

5. The July 1, 2015 CBRC rate increase of $22,925,000 is based on the 2010 audited PPS rate utilizing payment data from the Paid Claims Summary Reports for FY 2013-14. The estimated payment increase is determined by the difference between the calculated estimated payment and the total payments per the Paid Claims Summary reports for FY 2013-14.

(Dollars in Thousands)

	FY 2014-15	FY 2015-16
FQHCs Reconciliation	$89,288	$83,950
RHCs Reconciliation	$9,530	$12,593
FQHC Retroactive Rate Adjustment	$52,692	$62,333
LA CBRCs Reconciliation	$60,318	$57,603
July 2014 LA CBRC Rate Increase	$24,420	$24,420
July 2015 LA CBRC Rate Increase		$22,925
Total	**$236,248**	**$263,824**

Funding:

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

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	138
IMPLEMENTATION DATE:	4/2014
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1563

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$90,003,000	$90,002,000
- STATE FUNDS	$45,001,500	$45,001,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$90,003,000	$90,002,000
STATE FUNDS	$45,001,500	$45,001,000
FEDERAL FUNDS	$45,001,500	$45,001,000

DESCRIPTION

Purpose:
This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to freestanding nursing facilities (NF-Bs) through the Special Fund.

Authority:
SB 853 (Chapter 717, Statutes of 2010)
AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 implemented a quality and accountability supplemental payments (QASP) program for NF-Bs. The supplemental payments are tied to demonstrated quality of care improvements. Supplemental payments began April 2014 and are paid through the Special Fund. The Special Fund is comprised of penalties collected from skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2014-15 (up to a maximum of 1% of the overall rate), and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile.

AB 1489 implemented a 3% increase to the AB 1629 facilities weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years, and also extended quality assurance fee (QAF) and the QASP at the 1% level until July 31, 2015. In the absence of legislation, the AB 1629 facility-specific rate methodology, QAF, and QASP are scheduled to sunset. The Department is assuming continuation of the program beyond the July 31, 2015 sunset date with a 3.62% total annual rate increase. Instead of the 1% QASP, the QASP will continue at FY 2014-15 levels.

The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs that are not matched with Federal Financial

QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 138

Participation (FFP).

The Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change from Prior Estimate:
The change is due to updated program expenditures.

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.

2. The estimated incoming funds for the Special Fund are:

	FY 2014-15	FY 2015-16
Penalties on Nursing Facilities	$600,000	$600,000
1% Weighted Average Rate Increase	$43,143,000	$43,143,000
PLI savings	$5,692,000	$5,692,000

3. The penalties on nursing facilities will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. The total amount of supplemental payments will be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.

4. Estimated CDPH annual administrative costs are $5,066,000 TF ($2,533,000 Special Fund) for FY 2014-15 and $5,066,000 TF ($2,533,000 Special Fund) for FY 2015-16.

5. Supplemental payments are:

(Dollars In Thousands)

	TF	GF	SF	FF
FY 2014-15				
Supplemental Payments***	$90,003	$0	$45,001	$45,001
Transfer from GF* to Special Fund**	$0	$48,835	($48,835)	$0
Total	**$90,003**	**$48,835**	**($3,833)**	**$45,001**
FY 2015-16				
Supplemental Payments***	$90,002	$0	$45,001	$45,001
Transfer from GF* to Special Fund**	$0	$48,835	($48,835)	$0
Total	**$90,002**	**$48,835**	**($3,834)**	**$45,001**

Funding:
100% GF (4260-605-0001)*
SNF Quality & Accountability (less funded by GF) (4260-698-3167)**
SNF Quality & Accountability (4260-605-3167)***
Title XIX FFP (4260-101-0890)***

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER:	139
IMPLEMENTATION DATE:	8/2014
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1508

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$105,220,000	$190,082,000
- STATE FUNDS	$52,610,000	$95,041,000
PAYMENT LAG	0.9127	0.9332
% REFLECTED IN BASE	66.22 %	1.19 %
APPLIED TO BASE		
TOTAL FUNDS	$32,440,400	$175,273,600
STATE FUNDS	$16,220,190	$87,636,820
FEDERAL FUNDS	$16,220,190	$87,636,820

DESCRIPTION

Purpose:
This policy change estimates the cost of the AB 1629 rate increases for freestanding skilled nursing facilities (NF-Bs), which is partially funded by the Quality Assurance Fee (QAF).

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)
AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Managed Care Plans

Background:
AB 1629 requires the Department to implement a facility-specific rate methodology and impose a QAF on NF-Bs, including adult and pediatric subacute facilities. The QAF is used to offset the GF portion of the reimbursement rates.

The QAF is used as a means to enhance federal financial participation (FFP) for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities.

To determine the QAF amount assessed to these facilities, the Department uses two-year old data as the base revenue and applies growth and trending adjustments to project an estimate of revenues. The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is 6%, effective October 1, 2011. Changes in the amount of licensing and certification fees for NF-Bs, assessed by the California Department of Public Health (CDPH), affect the amount of QAF that can be collected in order to remain within the federal safe harbor limit.

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 139

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) Fund. Effective August 1, 2013, the revenue generated by the QAF collections will be deposited directly into the fund, rather than the state General Fund (GF), and will be used to offset provider reimbursement rate expenditures. AB 1489 implemented a 3% increase to the weighted average Medi-Cal reimbursement rate for the 2013-14 and 2014-15 rate years.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payments program (QASP) for freestanding nursing facilities (NF-Bs). The QASP will be tied to demonstrated quality of care improvements and paid through the Skilled Nursing Facility Quality and Accountability Special Fund. The fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2013-14 (up to a maximum of 1 % of the overall rate), and the savings achieved from setting the professional liability insurance cost category at the 75th percentile.

On July 31, 2015, in the absence of legislation, the AB 1629 facility-specific rate methodology, QAF, and QASP are scheduled to sunset. The Department is assuming continuation of the program beyond the July 31, 2015 sunset date with a 3.62% total annual rate increase.

Reason for Change from Prior Estimate:
The change is due to updated program expenditures.

Methodology:

1. Retroactive payments for rate year 2013-14, from August 1, 2013 through March 30, 2014, were paid in August, 2014.

2. Implementation date for rate increase is August 1.

3. Assume a 3% rate increase for 2014-15 rate year and a 3.62% rate increase for 2015-16 rate year.

4. The estimated managed care rate adjustment impact for rate years 2014-15 is already included in the managed care FY 2014-15 capitation rates.

5. Here is the estimated impact of AB 1629 beginning in 2010-11. Please note that the amounts shown are on a rate year basis (August 1 to July 31) and are accrual amounts.

(Dollars in thousands)

Rate Year	Total Expenditures	Non-Federal	Estimated QAF	General Fund	GF Increase	GF % Increase
2010-11	$3,844,274	$1,563,851	$430,596	$1,133,255		
2011-12	$3,985,346	$1,992,673	$469,962	$1,522,711	$389,457	34.37%
2012-13	$4,060,472	$2,030,236	$510,265	$1,519,971	($2,741)	-0.18%
2013-14*	$4,182,286	$2,091,143	$504,407	$1,586,736	$66,765	4.39%
2014-15*	$4,307,754	$2,153,877	$523,957	$1,629,920	$43,184	2.72%
2015-16**	$4,460,437	$2,230,219	$539,676	$1,690,543	$60,623	3.72%

*Includes QASP payments
**Assumes 3.62% rate increase and 14-15 level of QASP payments ($~90 million total)

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE

REGULAR POLICY CHANGE NUMBER: 139

(Dollars In Thousands)

FY 2014-15	TF	GF	FFP
FFS (Rate Increase)	$43,632	$21,816	$21,816
FFS (Retroactive Payment)	$61,588	$30,794	$30,794
Managed Care	$0	$0	$0
Total*	**$105,220**	**$52,610**	**$52,610**

FY 2015-16	TF	GF	FFP
FFS (Rate Increase)	$127,877	$63,939	$63,939
Managed Care	$62,205	$31,103	$31,103
Total*	**$190,082**	**$95,041**	**$95,041**

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

*Amounts may differ due to rounding.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER:	140
IMPLEMENTATION DATE:	11/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1612

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$42,280,000	$9,000,000
- STATE FUNDS	$21,140,000	$4,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$42,280,000	$9,000,000
STATE FUNDS	$21,140,000	$4,500,000
FEDERAL FUNDS	$21,140,000	$4,500,000

DESCRIPTION

Purpose:
This policy change estimates the increase in fee-for-service (FFS) and managed care (MC) payments and the offset of General Fund (GF) of the Medi-Cal reimbursement rate for emergency medical air transportation services.

Authority:
AB 2173 (Chapter 547, Statutes of 2010), Government Code 76000.10
AB 215 (Chapter 392, Statutes of 2011), Government Code 76000.10

Interdependent Policy Changes:
PC 131 Extend Gross Premium Tax
PC 123 Extend Gross Premium Tax – Incr. Capitation Rates
PC 132 Extend Gross Premium Tax – Funding Adjustment
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
AB 2173 imposed an additional penalty of $4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill required the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Air Medical Transportation Act (EMATA) Fund.

AB 215 eliminated the county's administrative costs by allowing the counties to remit their collections to the State under an existing process established in current law. This change in remittance procedures increases the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the remaining EMATA funds will be used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the fund will be matched with federal funds and used to augment the rate for Medi-Cal emergency medical air transportation services.

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 140

Federal approval to distribute EMATA supplemental payments to emergency medical air transportation providers was obtained on November 5, 2012 through SPA 12-001A. The Department provided supplemental payments for Medi-Cal emergency medical air transportation services provided to Medi-Cal beneficiaries from January 7, 2012 to June 30, 2012.

Federal approvals for SPA 12-001B were received May 19, 2014 for FY 2012-13 and FY 2013-14 augmentation payments. The Department anticipates the federal approval for SPA 14-031, which covers augmentation payments for services rendered between July 1, 2014 and June 30, 2015, will be received by December 31, 2014. The payment augmentation per transport amount is calculated annually.

Reason for Change from Prior Estimate:
The change is due to:

- The first six months of FY 2013-14 FFS augmentation payments were paid in June 2014 and the second half will be paid in October 2014.
- Due to a delay in processing, no MC payments were made in FY 2013-14. The MC augmentation payments for services rendered in FY 2012-13 and FY 2013-14 will be made in FY 2014-15.
- Revised penalty collections.

Methodology:

1. Implementation date began November 2012.

2. Phase I: EMATA Supplemental Payments were made in FY 2012-13

3. Phase II: EMATA augmentation payments will be adjusted annually based on penalties collected from most vehicle violation convictions. 20% of the amount will be used to offset GF costs of emergency medical air transportation services for the same fiscal year. The remaining 80% will be matched with federal funds and used to augment the rate for FFS and MC emergency medical air transportation services.

4. For services rendered in FY 2012-13:
    a. Retroactive FFS augmentation payments were made in June 2014, and
    b. MC payments for FY 2012-13 will be paid in June 2015.

5. For services rendered in FY 2013-14:
    a. FFS augmentation payments for the first half of FY 2013-14 were made in June 2014,
    b. FFS augmentation payments for the second half of FY 2013-14 will be made in October 2014, and
    c. MC payments will be made in June 2015.

6. For services rendered in FY 2014-15:
    a. FFS augmentation payments will be made in June 2015, and
    b. MC payments will be made in June 2015.

7. For services rendered in FY 2015-16:
    a. FFS augmentation payments will be made in August 2015, and
    b. MC payments will be made in August 2016.

8. The estimated EMATA funds for Phase II on an accrual basis are:

EMERGENCY MEDICAL AIR TRANSPORTATION ACT

REGULAR POLICY CHANGE NUMBER: 140

	EMATA Fund	GF Offset (20%)	Available for Rate Augmentation
FY 2012-13	$13,750,000	$2,750,000	$11,000,000
FY 2013-14	$11,250,000	$2,250,000	$9,000,000
FY 2014-15	$11,250,000	$2,250,000	$9,000,000
FY 2015-16	$11,250,000	$2,250,000	$9,000,000

9. The estimated payments on a cash basis are:

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**EMATA**	**FFP**
GF Offset	$0	($5,285)	$5,285	
Fee For Service	$13,500		$6,750	$6,750
Managed Care	$28,780		$14,390	$14,390
Total	**$42,280**	**($5,285)**	**$26,425**	**$21,140**
FY 2015-16				
GF Offset	$0	($1,125)	$1,125	
Fee For Service	$9,000		$4,500	$4,500
Managed Care	$0		$0	$0
Total	**$9,000**	**($1,125)**	**$5,625**	**$4,500**

Funding:
100% GF (4260-101-0001)
Title XIX FFP (4260-101-0890)
EMATA Fund (4260-101-3168)

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER:	141
IMPLEMENTATION DATE:	8/2014
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1021

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$22,607,000	$92,985,000
- STATE FUNDS	$11,303,500	$46,492,500
PAYMENT LAG	0.8212	0.9135
% REFLECTED IN BASE	1.97 %	0.47 %
APPLIED TO BASE		
TOTAL FUNDS	$18,199,100	$84,542,600
STATE FUNDS	$9,099,570	$42,271,280
FEDERAL FUNDS	$9,099,570	$42,271,290

DESCRIPTION

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

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

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans – Funding Adjustment
PC 135 MCO Tax Managed Care Plans

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

Reason for Change from Prior Estimate:
The changes are due to updated data and additional add-ons.

Methodology:
1. Implementation date for AB 1629 add-ons will be August 1, 2014 for the 2014-15 rate year and August 1, 2015 for 2015-16 rate year.

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER: 141

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

3. The estimated add-ons rates are already included in the managed care FY 2014-15 and FY 2015-16 capitation rates.

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

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

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

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

8. Effective July 1, 2014, AB 10 (Chapter 351, Statutes of 2013) increases the minimum wage to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour. The minimum wage was previously $8.00 per hour. An add-on of $0.07 will be applied to the rate to reimburse facilities for additional cost for the 2014-15 rate year and $0.27 for the 2015-16 rate year.

9. Effective January 1, 2015, The Employer Mandate and Affordable Care Act (ACA) requires Skilled Nursing Facility employers to offer health care coverage to 70% of their full time employees in 2015 and 95% in 2016 and beyond. An add-on of up to $2.34 will be applied to the rate to reimburse facilities for additional costs for the 2014-15 and 2015-16 rate years.

10. Effective July 1, 2015, AB 1522 (Chapter 317, Statutes of 2014) requires employers to provide employees paid sick days of no less than one hour for every 30 hours worked. Employees are limited to using 24 hours of sick leave during each year of employment. An add-on of $1.72 will be applied to the rate to reimburse facilities for the additional cost in the rate year 2015-16.

	(Total Fund)	
FFS	**FY 2014-15**	**FY 2015-16**
ACA Reinsurance and PCORI	$549,000	$599,000
ACA Compliance Program	$9,053,000	$9,876,000
FUTA	$1,509,000	$1,646,000
HIPAA EFT and E-RADs	$411,000	$449,000
Minimum Wage	$960,000	$4,751,000
New-ACA Employer Mandate	$10,125,000	$52,072,000
New-Paid Sick Leave	$0	$23,592,000
FFS Total	$22,607,000	$92,985,000
Managed Care	$0	$0
Total*	**$22,607,000**	**$92,985,000**

AB 1629 ADD-ONS

REGULAR POLICY CHANGE NUMBER: 141

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

*Amounts may differ due to rounding.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	142
IMPLEMENTATION DATE:	8/2007
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1046

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$28,585,000	$75,945,000
- STATE FUNDS	$14,292,500	$37,972,500
PAYMENT LAG	0.8401	0.8842
% REFLECTED IN BASE	2.53 %	0.13 %
APPLIED TO BASE		
TOTAL FUNDS	$23,406,700	$67,063,300
STATE FUNDS	$11,703,350	$33,531,640
FEDERAL FUNDS	$11,703,350	$33,531,640

DESCRIPTION

Purpose:
This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-As (NF-A), Distinct Part (DP) Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, DP Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. Additionally, it estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF-DDs and Freestanding (FS) Pediatric Subacute facilities. It also estimates the additional reimbursement for the projected Medi-Cal costs of complying with new State or federal mandates, referred to as “add-ons.”

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 149 Non-AB 1629 LTC Rate Freeze
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Pursuant to the State Plan requirements, Medi-Cal rates for LTC facilities are adjusted after completion of an annual rate study.

ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

LTC RATE ADJUSTMENT

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Effective June 1, 2011, AB 97 requires the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition, AB 97 extends this requirement to the other long term care facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% reduction and rate freeze at the 2008-2009 rate level, required by AB 97, with respect to DP/NF-Bs. On December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction.

On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunctions. The Department will implement the AB 97 payment reduction and rate freeze retroactive to June 1, 2011. Due to access concern, on December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels in addition to the 10% payment reduction, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and 10% payment reduction, effective October 1, 2013.

The Department also received CMS approval not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its access and utilization analyses.

Reason for Change from Prior Estimate:

- Updated rate information
- New add-ons

Methodology:

1. No rate increase is assumed for NF-As, Rural Swing Beds, and FS Pediatric Subacute facilities during rate years (RYs) 2014-15 and 2015-16.

2. The add-ons are negotiated on an annual basis and reflect costs associated with new mandates that have yet to be captured within the audited cost reports used to compute facility specific reimbursement rates. These new mandated costs are budgeted separately, as they will take two years to be reflected in the regular facility specific reimbursement rates, except for DP Adult Subacute where it will take three years to be reflected in their rates.

3. Assume add-ons remain in place for ongoing costs for providers' rates impacted by a rate freeze.

4. **DP Adult Subacute and DP Pediatric Subacute facilities**: These two facilities will not be subject to any rate reductions. The Department completed a "Monitoring Access to Medi-Cal Covered Services" study that determined reducing or freezing reimbursement rates for these two facilities would negatively impact access to care. Therefore, the Department will be increasing

LTC RATE ADJUSTMENT

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reimbursement rates for these facility types under the "normal" rate setting process.

5. **DP/NF-B facilities:** The impact of implementation of rate freeze and exemption is budgeted in the Non-AB 1629 LTC Rate Freeze policy change.

6. **ICF/DD, ICF/DD-H, and ICF/DD-N facilities:** The Department implemented the 2013-14 rate using the new rate methodology in June 2014.

7. ABX1 19 requires FS Pediatric Subacute Care facilities to pay a QA fee beginning January 1, 2012. Effective October 1, 2011, the QA fee cap increased from 5.5% to 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.

8. Effective October 1, 2010, CMS mandated that FS skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0). Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. The rate increase was effective August 1, 2011. The add-on amount of $0.51 will remain the same for providers impacted by the rate freeze for RYs 2014-15 and 2015-16.

9. Effective October 2009, the Division of Occupational Safety and Health (CAL/OSHA) required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional cost was effective August 1, 2011. The add-on amount of $0.25 will remain in effect RYs 2014-15 and 2015-16 for providers impacted by the rate freeze. The ICF/DD-H and ICF/DD-N facilities receiving the frozen 08-09 rates will receive $0.48.

10. Adult Day Holiday mandated add-on reimburses ICF/DD facilities for adult day care or transportation service during the period between Christmas and New Years. A $0.16 through $0.22 add-on to the rate, to reimburse facilities, remains the same for RYs 2014-15 and 2015-16 for providers impacted by the rate freeze.

11. AB 1835 (Chapter 230, Statutes of 2006) required an increase in the minimum wage in California. The add-on was applied to the rate, effective August 1, 2008. Due to the new rate methodology for ICF/DD provider types, the minimum wage is not captured in the frozen 2008-09 rate. An add-on from $0.18 through $0.25 to the rates to reimburse the facilities for the additional costs will be effective for RYs 2014-15 and 2015-16 for providers receiving the frozen 2008-09 rates.

12. Effective January 2011, the California Department of Public Health (CDPH) mandates LTC facilities to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on of $0.11 will be added to the rates to reimburse DP Subacute Care providers for the additional costs for RY 2014-15. An add-on from $0.11 through $0.19 will remain the same for RYs 2014-15 and 2015-16 for the providers impacted by the rate freeze.

13. The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on from $0.11 through $0.22 to the rate to reimburse facilities will be effective for the RY 2014-15. The add-on amount for RYs 2014-15 and 2015-16 will increase to $0.22 through $0.32 for providers impacted by the rate freeze.

14. Effective April 2012, CDPH requires providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on of $0.02 to the rates

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to reimburse the DP Subacute Care facilities for the additional costs is effective for RY 2014-15 and will remain the same for RYs 2014-15 and 2015-16 for providers impacted by the rate freeze excluding ICF/DD providers.

15. Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An add-on of $0.04 reimburses DP Subacute Care facilities for compliance costs for RY 2014-15. An add-on from $0.01 through $0.04 will remain the same for RYs 2014-15 and 2015-16 for providers impacted by the rate freeze.

16. The Patient Protection and Affordable Care Act (ACA) assessed two new fees on employers providing health insurance, an annual reinsurance fee, effective January 1, 2014 and a Patient-Centered Outcomes Research Trust Fund Fee (PCORI) per covered life, effective December 6, 2012. An add-on of $0.04 through $0.07 will be effective for RY 2014-15 and will remain the same for DP Subacute Care providers and those impacted by the freeze RY 2015-16.

17. Effective March 23, 2013, the ACA requires Skilled Nursing Facilities to implement a compliance and ethics program. An add-on of $0.66 will be provided to cover costs associated with implementing this program and will be effective for RY 2014-15 and will remain the same for DP Subacute Care providers and those impacted by the freeze RY 2015-16 excluding ICF/DD providers.

18. The Health Insurance and Portability and Accountability Act (HIPAA) issued new regulations regarding the use of electronic fund transfers (EFT) and electronic remittance advices (RA). A $0.03 add-on will be provided for associated training costs and will be effective for RY 2014-15 and remain the same for DP Subacute Care providers and those impacted by the freeze RY 2015-16 excluding ICF/DD-H and ICF/DD-N facilities.

19. AB 10 (Chapter 351, Statutes of 2013) increase the minimum wage, after July 1, 2014 to not less than $9.00 per hour and on and after January 1, 2016, to not less than $10.00 per hour. The current minimum wage is $8.00 per hour. An add-on of $$0.10 through $6.58 will be applied to the rate to reimburse the facilities for the additional cost beginning RY 2014-15. The add-on amount for RY 2015-16 will increase to $0.10 through $9.62.

20. Effective January 1, 2015, the ACA Employer Mandate requires employers to offer health care coverage to 70% of their full time employees in 2015 and 95% in 2016 and beyond. An add-on of up to $6.51 will be applied to the rate to reimburse facilities for additional costs for RYs 2014-15 and 2015-16.

21. Effective July 1, 2015, AB 1522 (Chapter 317, Statutes of 2014) requires employers to provide employees paid sick days of no less than one hour for every 30 hours worked. Employees are limited to using 24 hours of sick leave during each year of employment. An add-on of $1.72 through $4.17 will be applied to the rate to reimburse facilities for the additional cost in RY 2015-16.

22. The estimated costs of managed care rate increase for FY 2014-15 and FY 2015-16 are already included in the managed care FY 2014-15 and FY 2015-16 capitation rates.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 142

(Dollars in Thousands)

Fee-for-Service	**FY 2014-15**	**FY 2015-16**
Rate Adjustment	$3,115	$4,751
MDS 3.0	$109	$10
Adult Day Holiday	$434	$39
Minimum Wage (ICF/DD only)	$470	$43
Vaccine	$1,164	$106
Informed Consent	$60	$5
FUTA	$461	$42
Std Adm Agreement	$15	$1
Elder Justice Act	$97	$9
ACA Reinsurance Fee & PCORI	$237	$22
ACA Compliance Program	$1,064	$97
FUTA	$533	$48
HIPPA EFT and RA	$56	$5
New - ACA Employer Mandate	$5,911	$985
New - Minimum Wage (July 2014)	$14,860	$1,351
Rate Adjustment		$8,293
MDS 3.0		$109
Adult Day Holiday		$434
Minimum Wage		$470
Vaccine		$1,164
Informed Consent		$22
FUTA		$422
Std Adm Agreement		$4
Elder Justice Act		$90
ACA Reinsurance Fee & PCORI		$163
ACA Compliance Program		$372
FUTA		$417
HIPPA EFT and RA		$24
New - ACA Employer Mandate		$19,247
New - Minimum Wage (July 2014)		$23,099
New - Sick Leave (July 2015)		$14,100
Total FFS	$28,585	$75,945
Managed care	$0	$0
Total Cost	**$28,585**	**$75,945**

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

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	143
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1185

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$21,979,000	$0
- STATE FUNDS	$9,022,600	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,979,000	$0
STATE FUNDS	$9,022,600	$0
FEDERAL FUNDS	$12,956,400	$0

DESCRIPTION

Purpose:
This policy change budgets the retroactive adjustments to dental managed care and Fee-for-Service rates impacting prior fiscal years.

Authority:
Welfare & Institutions Code 14301(a)

Interdependent Policy Changes:
Not Applicable

Background:
The W&I code authorizes the Department to determine the annual rate of payment for services provided for Medi-Cal beneficiaries enrolled in Denti-Cal or a prepaid health plan and to implement the new annual rates through an amendment or change order to the contract.

In the event there is any delay in a determination of rate changes, the amendment or change order may not be processed in time to permit payment of new rates commencing July 1. The payment to contractors shall continue at the current rates. Those continued payments shall constitute interim payments only. Upon final approval of the revised rates, the Department shall make retroactive adjustments for those months for which interim payments were made.

In August 2012, the Department terminated their contracts with one of the plans due to the plan's inability to maintain the requirements of their Knox Keene license. The Department also terminated their contracts with another plan which planned to cease operations effective June 1, 2012. The Department determined of the estimated $1.179 million owed, $879,000 has been collected. The remaining balance of $300,000 is still outstanding. Additionally, this amount may be uncollectable based on the financial status of the plan.

Reason for Change from Prior Estimate:
The changes are due to the increase in monthly eligibles and updated rates.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 143

Methodology:

1. The Program of All-Inclusive Care for the Elderly (PACE) retroactive rate adjustments are reflected in the PACE (Other M/C) policy change.

2. The Senior Care Action Network (SCAN) retroactive rate adjustments are reflected in the Senior Care Action Network policy change.

3. Assume the ACA eligibles are included in this policy change.

Rate Period	Existing Rate	New Rate	Change	Eligible Months	Dental Retro Rate Adjustment
GMC <21					
01/01/2013 - 06/30/2013	$10.58	$11.59	$1.01	887,436	$896,310
07/01/2013 - 09/30/2013	$10.58	$12.06	$1.48	469,861	$695,394
10/01/2013 - 04/30/2014	$10.58	$11.05	$0.47	1,160,390	$545,383
05/01/2014 - 06/30/2014	$10.58	$11.05	$0.47	384,189	$180,569
					$2,317,657
21+					
01/01/2013 - 06/30/2013	$1.48	$2.07	$0.59	507,800	$299,602
07/01/2013 - 09/30/2013	$1.48	$2.10	$0.62	269,455	$167,062
10/01/2013 - 04/30/2014	$1.48	$1.99	$0.51	666,148	$339,735
05/01/2014 - 06/30/2014	$1.48	$7.71	$6.23	220,826	$1,375,746
					$2,182,146
PHP <21					
01/01/2013 - 06/30/2013	$10.58	$13.94	$3.36	1,497,618	$5,031,996
07/01/2013 - 09/30/2013	$10.58	$13.94	$3.36	889,512	$2,988,760
10/01/2013 - 04/30/2014	$10.58	$12.76	$2.18	2,055,256	$4,480,458
05/01/2014 - 06/30/2014	$10.58	$12.76	$2.18	611,753	$1,333,622
					$13,834,836
21+					
01/01/2013 - 06/30/2013	$1.48	$2.19	$0.71	582,634	$413,670
07/01/2013 - 09/30/2013	$1.48	$2.19	$0.71	333,324	$236,660
10/01/2013 - 04/30/2014	$1.48	$2.07	$0.59	765,162	$451,446
05/01/2014 - 06/30/2014	$1.48	$8.39	$6.91	228,515	$1,579,039
					$2,680,814

Total FY 2013-14 Dental Retroactive Adjustments	$21,015,000
Total GF FY 2013-14	$10,507,500

Delta Dental Rate Period	Existing Rate	New Rate	Change	Eligible Months	Dental Retro Rate Adjustment
7/1/2013 - 9/30/2013	$5.74	$5.74	$0.00	19,827,275	$0
10/1/2013 - 4/30/2014	$5.74	$5.22	($0.52)	52,151,904	($27,119,000)
5/1/2014 - 6/30/2014	$5.74	$7.41	$1.67	16,809,244	$28,071,000
					$952,000

DENTAL RETROACTIVE RATE CHANGES

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Refugees					
7/1/2013 - 9/30/2013	$3.22	$3.22	$0.00	6,566	$0
10/1/2013 - 4/30/2014	$3.22	$2.93	($0.29)	15,336	($4,000)
5/1/2014 - 6/30/2014	$3.22	$6.90	$3.68	4,256	$16,000
					$12,000
Total FY 2013-14 Dental Retroactive Adjustments					$964,000

FY 2014-15 (cash basis)	
GMC and PHP Dental	$21,015,000
Delta Dental	$964,000
Total FY 2014-15	**$21,979,000**

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

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER:	144
IMPLEMENTATION DATE:	10/2005
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	88

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$20,784,000	$20,625,000
- STATE FUNDS	$10,392,000	$10,312,500
PAYMENT LAG	0.9077	0.9102
% REFLECTED IN BASE	60.46 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,459,500	$18,772,900
STATE FUNDS	$3,729,740	$9,386,440
FEDERAL FUNDS	$3,729,740	$9,386,440

DESCRIPTION

Purpose:
This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

Authority:
Section 1833 of the Social Security Act

Interdependent Policy Changes:
Not Applicable

Background:
The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. The clinic receives an annual rate adjustment based on the percentage increase in the MEI and is effective October 1st of each year.

Reason for Change from Prior Estimate:
Updated utilization data for FY 2011-12, FY 2012-13, and FY 2013-14 were used to project subsequent MEI rates and estimated annual payments.

Methodology:
1. Assume utilization will increase 0.6% (rounded) in year 2014 and 3.54% (rounded) in year 2015. Utilization is based on the average percent increase of visits over the preceding three years.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 144

2. Apply the utilization factors to the projected 2013 visits.

2013 Visits		**2014 Visits**
10,443,641	0.6%	10,505,894

2014 Visits		**2015 Visits**
10,505,894	3.54%	10,878,306

3. The annual MEI increase will be used as a trend factor to calculate the estimated cost per visit (rate). The MEI increase percent for years 2013 and 2014 is 0.8%. The MEI increase percent is 0.73% for year 2016. Therefore, the rates are:

	Rate without MEI	Rate with MEI
2014	$141.74	$141.74 x (1+0.8%) = $142.87
2015	$142.87	$142.87 x (1+0.8%) = $144.01
2016	$144.01	$144.01 x (1+0.73%) = $145.07

4. The estimated expenditures are the estimated rate multiplied the estimated visits. The annual expenditures due to MEI increase are:

(Dollars in thousands)

	Expenditures without MEI	Expenditures with MEI	MEI Increase
2014	$1,480,282	$1,492,083	$11,801
2015	$1,500,977	$1,512,954	$11,977
2016	$1,566,585	$1,578,116	$11,531

5. For FY 2014-15, the total MEI increase includes an annualized MEI increase for year 2013 of $11,801,000 and nine months of year 2014 MEI increase of $8,983,000.

6. For FY 2015-16, the total MEI increase includes an annualized MEI increase for year 2014 of $11,977,000 and nine months of year 2014 MEI increase of $8,648,000.

(Dollars in thousands)

FY 2014-15	**TF**	**GF**
2013 MEI Increase	$11,801	$5,901
2014 MEI Increase	$8,983	$4,491
Total (Rounded)	**$20,784**	**$10,392**

FY 2015-16		
2014 MEI Increase	$11,977	$5,989
2015 MEI Increase	$8,648	$4,324
Total (Rounded)	**$20,625**	**$10,313**

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

GENETIC DISEASE SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER:	145
IMPLEMENTATION DATE:	11/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1841

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$7,482,000	$7,482,000
- STATE FUNDS	$3,741,000	$3,741,000
PAYMENT LAG	0.8000	0.9900
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,985,600	$7,407,200
STATE FUNDS	$2,992,800	$3,703,590
FEDERAL FUNDS	$2,992,800	$3,703,590

DESCRIPTION

Purpose:
This policy change estimates the costs associated with a fee increase for prenatal screening provided to Medi-Cal beneficiaries under the Genetic Disease Screening Program (GDSP).

Authority:
Health & Safety Code Section 124977

Interdependent Policy Changes:
Not Applicable

Background:
CDPH administers California's GDSP, which includes the Prenatal Screening (PNS) Program and the Newborn Screening (NBS) Program. These programs screen for genetic disorders that are, for the most part, preventable or remediable by early intervention and provide clinical oversight for the follow-up services, which include genetic counseling and confirmatory testing, including ultrasound and diagnostic procedures.

Effective July 1, 2014, GDSP implemented a $45 fee increase for their prenatal screening program. This increase is in accordance with Health & Safety Code Section 124977, which requires that the amount of the fee shall be periodically adjusted to fully support the program.

Reason for Change from Prior Estimate:
The changes are due to updated caseload and incorporation of Medi-Cal collection rate.

Methodology:
1. Effective July 1, 2014, GDSP implemented a $45 fee increase for the prenatal screening program.

2. CDPH estimates 377,046 women will have prenatal screening in FY 2014-15 and FY 2015-16. Approximately 45% of them are Medi-Cal beneficiaries.

GENETIC DISEASE SCREENING PROGRAM FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 145

3. Assume 98% of claims submitted are paid.

   377,046 x 45% x 98% x $45 = $7,482,000 ($3,741,000) Rounded

4. The estimated costs for FY 2014-15 and FY 2015-16 on a cash basis are:

(Dollars in Thousands)

	TF	GF	FF
FY 2014-15	**$7,482**	**$3,741**	**$3,741**
FY 2015-16	**$7,482**	**$3,741**	**$3,741**

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

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER:	146
IMPLEMENTATION DATE:	10/2006
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	96

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$7,684,000	$14,901,000
- STATE FUNDS	$3,842,000	$7,450,500
PAYMENT LAG	0.8043	0.8748
% REFLECTED IN BASE	2.07 %	1.19 %
APPLIED TO BASE		
TOTAL FUNDS	$6,052,300	$12,880,300
STATE FUNDS	$3,026,160	$6,440,140
FEDERAL FUNDS	$3,026,160	$6,440,140

DESCRIPTION

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the Social Security Act

Interdependent Policy Changes:
Not Applicable

Background:

1. **Hospice Services**
   Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

2. **Hospice Room and Board**
   The Department ties each hospice facility's room and board rate to 95% of the individual facility's affiliated rates for Nursing Facility – Level B (NF-B), which include Distinct Part (DP) or Freestanding; Nursing Facility – Level A (NF-A); Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled – Nursing (ICF/DD-N), and Intermediate Care Facility for the Developmentally Disabled – Habilitative (ICF/DD-H). This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

   Pursuant to ABX4 5 (Chapter 5, Statutes of 2009), hospice room and board rates were frozen to 2008-09 levels for rate years 2009-10 and 2010-11, in those cases where the facility's per-diem rate was frozen. AB 97 (Chapter 3, Statutes of 2011) allows the Department to decide whether to implement further rate freezes and payment reductions for long-term care facilities (LTCs), effective June 1, 2011. The Department removed the rate freeze for certain LTCs.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 146

Subsequently, SB 239 (Chapter 657, Statutes of 2013) required the Department to remove the DP/NF-B providers from the rate freeze and payment reductions on a prospective basis. Hospice room and board rates will increase based on the nursing facility rate increases.

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

- Updated data
- 100% of FY 2013-14 expenditures are in the base.

Methodology:

1. The estimated weighted increase for hospice service rates for FY 2014-15 and FY 2015-16 are 2.12% and 2.11% respectively.

2. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

   The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP NF-Bs, and Freestanding Pediatric Subacute rates.

   Effective June 1, 2012, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

   SB 239 (Chapter 657, Statutes of 2013) required the Department to remove prospectively the DP/NF-B providers from the rate freeze and payment reductions. The Department elected to not implement the rate freeze for all LTC facility types based on its access and utilization analyses. CMS has already approved the Department's request to not implement a rate freeze on DP Adult and Pediatric Subacute rates.

   Hospice room and board rates will continue at 95% of the facility rates, whether frozen or unfrozen.

3. The weighted increase for hospice room and board rates for FY 2014-15 and FY 2015-16 is estimated to be 4.37%.

(Dollars in Thousands)

	FY 2014-15	FY 2015-16
FY 2013-14 - Retroactive Payments	$1,362	
FY 2014-15 - Hospice Services	$1,422	$1,897
FY 2014-15 - Room & Board	$4,899	$5,345
FY 2015-16 - Hospice Services		$2,071
FY 2015-16 - Room & Board		$5,588
TOTAL*	**$7,684**	**$14,901**

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 146

Funding:
50% GF / 50% Title XIX (4260-101-0001/0890)
*Amounts may differ due to rounding.

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER:	147
IMPLEMENTATION DATE:	8/2013
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1784

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change budgets the funding adjustment from the Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund (GF).

Authority:
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
AB 1762 (Chapter 230, Statutes of 2003) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down a federal match, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. The following LTC providers are subject to a QA fee:

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

On July 31, 2015, in the absence of legislation, the AB 1629 facility-specific rate methodology and QA program are scheduled to sunset. The Department is assuming continuation of the program beyond the July 31, 2015 sunset date.

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA and ICF-DDs fees collected are deposited into the fund, rather than the state General Fund, which are used

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 147

for LTC provider reimbursement rate expenditures.

Reason for Change from Prior Estimate:
The change is due to updated fee collection data.

Methodology:
1. Based on three years of LTC QA fee collection data, the average annual LTC QA fee revenue on a cash basis is $435,927,000 and the average rate of change is (0.72%).

2. Based on FY 2013-14 actual QA fee transfer data, 89.88% of fee collection is transferred to GF in the current year. Assume the remaining QA fee will be transferred to GF in the next fiscal year.

3. The estimated fund adjustment from the LTCQAF to GF is:

(Dollars In Thousands)

		TF	GF	LTCQAF
FY 2014-15				
	FY 2013-14	$0	($42,038)	$42,038
	FY 2014-15	$0	($391,825)	$391,825
Total		**$0**	**($433,863)**	**$433,863**
FY 2015-16				
	FY 2014-15	$0	($44,102)	$44,102
	FY 2015-16	$0	($412,365)	$412,365
Total		**$0**	**($456,467)**	**$456,467**

Funding:
Long Term Care Quality Assurance Fund (4260-101-3213)
100% General Fund (4260-101-0001)

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER:	148
IMPLEMENTATION DATE:	1/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1703

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$20,926,000	-$59,671,000
- STATE FUNDS	-$10,463,000	-$29,835,500
PAYMENT LAG	0.7003	0.9300
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$14,654,500	-$55,494,000
STATE FUNDS	-$7,327,240	-$27,747,020
FEDERAL FUNDS	-$7,327,240	-$27,747,020

DESCRIPTION

Purpose:
This policy change estimates savings related to a clinical laboratory reimbursement reduction of up to 10%, and the savings from a new clinical laboratory reimbursement methodology.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
AB 1494 (Chapter 28, Statutes of 2012)
AB 1124 (Chapter 8, Statutes of 2014)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1494 allows the Department to develop a new rate methodology for clinical laboratory and laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2012), AB 1494 allows payments to be reduced by 10% for clinical lab services for dates of service on and after July 1, 2012. The 10% payment reduction pursuant to AB 1494 shall continue until the new rate methodology has been approved by the Centers for Medicare and Medicaid Services (CMS). The Family Planning, Access, Care, and Treatment Program (FPACT) shall be exempt from the payment reduction as specified in AB 1494. The new methodology does not exclude FPACT.

Reason for Change from Prior Estimate:
The changes are due to delay in expected federal approval:
- Implementation date for the new lab rate methodology has changed from November 2014 to June 2015.
- Implementation date for the 10% payment reduction has changed from September 2014 to January 2015.
- Updated data.

Methodology:
1. Assume savings will begin upon CMS approval and the subsequent California Medicaid Management

LABORATORY RATE METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 148

Information System (CA-MMIS) system implementation. The system implementation for the 10% payment reduction is anticipated to take place in January 2015. The retroactive date for the 10% payment reduction is July 1, 2012.

2. CMS approval for the new laboratory rate methodology is expected to be received April 2015 and implementation will begin June 2015.

3. The AB 97 (Chapter 3, Statutes of 2011) 10% reduction will be assessed after the AB 1494 10% reduction and new laboratory rate methodology reduction. .

4. Annual savings due to the AB 1494 10% payment reduction are projected to be $25,525,000 TF.

5. The total recoupment of the retroactive 10% savings from July 1, 2012 to December 31, 2014, is estimated to be $63,813,000 TF and is expected to be recovered over 60 months beginning January 2015.

6. Savings in FY 2014-15 will consist of six months of the 10% payment reduction, one month of the new lab rate methodology and six months of retroactive savings.

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
FY 2014-15 Savings	$14,545	$7,272	$7,272
Retroactive Savings	$6,381	$3,191	$3,191
Total*	**$20,926**	**$10,463**	**$10,463**

FY 2015-16	**TF**	**GF**	**FF**
FY 2015-16 Savings	$46,908	$23,454	$23,454
Retroactive Savings	$12,763	$6,381	$6,381
Total*	**$59,671**	**$29,835**	**$29,835**

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

*Amounts may differ due to rounding.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER:	149
IMPLEMENTATION DATE:	11/2013
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1597

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$6,634,000	-$26,283,000
- STATE FUNDS	-$3,317,000	-$13,141,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.66 %	0.06 %
APPLIED TO BASE		
TOTAL FUNDS	-$6,590,200	-$26,267,200
STATE FUNDS	-$3,295,110	-$13,133,620
FEDERAL FUNDS	-$3,295,110	-$13,133,620

DESCRIPTION

Purpose:
This policy change estimates the savings due to the rate being frozen at 2008-09 levels for Distinct Part/Nursing Facility-Level B (DP/NF-B) and Rural Swing Bed rates.

DP Adult Subacute and DP Pediatric Subacute facilities are not subject to the rate freeze.

Nursing Facility-Level A (NF-A), Freestanding Pediatric Subacute providers, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (H) and ICF/DD-Nursing (N) provider rates are currently reimbursed at the 2008-09 rate levels and are not impacted by this policy.

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
Effective August 1 of each year, LTC rates are re-determined for the following facility types: NF-A, DP/NF-B, Rural Swing Bed, DP Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, ICF-DD, ICF/DD-H, and ICF/DD-N.

ABX4 5 eliminated rate increases for these facilities effective August 1, 2009. In the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute providers, effective February 24, 2010.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 149

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-B.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% payment reduction and freeze at the rates established in 2008-2009, required by AB 97, with respect to DP/NF-B facilities. On December 28, 2011, the federal court issued a preliminary injunction.

On December 13, 2012, the United States Court of Appeal for the Ninth Circuit issued a decision in which it reversed the previous issued injunctions against AB 97 payment reductions and rate freezes. On January 28, 2013, the plaintiffs had requested a rehearing. On May 24, 2013, the Ninth Circuit denied the plaintiff's request for rehearing and on June 25, 2013, issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reductions and rate freezes retroactive to June 1, 2011.

The Department received CMS approval not to implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on their access and utilization analyses.

On December 20, 2013, the Department received CMS approval to exempt:

- DP/NF-B facilities located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B facilities from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective October 1, 2013.

Reason for Change from Prior Estimate:
Delay in implementation for DP/NF-B facilities due to system delays.

Methodology:

1. The effective date of AB 97 rate freeze is June 1, 2011.

2. **Rural Swing Bed rates**: Effective July 22, 2013, Rural Swing Bed rates are paid at the 2008-09 level rate. Prior to this, the providers received the unfrozen 2010-11 level rate. Assume the Department will recover rate freeze retroactive savings over 24 months beginning November 2013. The savings will be from August 1, 2011, through July 21, 2013.

3. **DP/NF-B facilities:** They are currently being paid at the 2013-14 level. Effective September 1, 2013, rural and frontier designated DP/NF-B providers will be paid at the 2013-14 level, and non-rural/frontier designated DP/NF-B providers will be paid at the 2013-14 level, effective October 1, 2013. The Department will recover rate freeze retroactive savings beginning April 2015 over 66 months.

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

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER:	150
IMPLEMENTATION DATE:	5/2012
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1579

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$9,552,000	-$20,837,000
- STATE FUNDS	-$4,776,000	-$10,418,500
PAYMENT LAG	0.9819	1.0000
% REFLECTED IN BASE	24.96 %	10.39 %
APPLIED TO BASE		
TOTAL FUNDS	-$7,038,100	-$18,672,000
STATE FUNDS	-$3,519,040	-$9,336,020
FEDERAL FUNDS	-$3,519,040	-$9,336,020

DESCRIPTION

Purpose:
This policy change estimates the savings due to the implementation of provider payment reductions applied to nursing and subacute facilities reimbursed under AB 1629 (Chapter 875, Statutes of 2004) reimbursement methodology, Nursing Facility - A (NF-A), Distinct Part Nursing Facility - B (DP/NF-B), Freestanding (FS) Adult Subacute Facility, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD - Nursing (N), and ICF/DD - Habilitative (H) providers based on AB 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers.

Effective June 1, 2011, AB 97 required the Department to reduce payments to long-term care facilities by up to 10% in FFS and the actuarially equivalent of that amount in managed care. However, ABX1 19 required the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% below rate year 2008-09 rates.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 150

Additionally, under ABX1 19, the 10% payment reduction for AB 1629 facilities ended on July 31, 2012. The Department did not implement the 5.75% payment reduction for the Freestanding Pediatric Subacute facilities, because it determined access would be compromised.

As a result of AB 97, the Department revised the reimbursement rate methodology for the ICF/DD, ICF/DD-H, and ICF/DD-N providers. Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H, and ICF/DD-N provider will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97. On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunction. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.

Due to access concern, on December 20, 2013, CMS approved the Department's request to exempt:

- DP/NF-B providers located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B providers from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rates as required by AB 97, effective October 1, 2013.

The actuarial equivalent of FFS payment reductions to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care is determined on a prospective basis.

Reason for Change from Prior Estimate:

- Delay in implementation of recoupment for DP/NF-B providers due to system delays.
- Updated program expenditures.
- This policy change does not include the managed care savings. Managed care savings are now budgeted in the managed care related policy changes.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes.

2. **FFS:** The Department implements the FFS payment reduction in various phases.
   - **AB 1629 Facilities:** This phase includes FS NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.
   - **ICF/DDs:** This phase includes ICF/DD, ICF/DD-N, and ICF/DD-H providers.
   - **DP/NF-Bs**: These are the previously enjoined providers.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 150

3. Due to access concerns, the Department will forgo the retroactive recoupment for ICF DDs.

Facility Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
ICF/DDs	6/1/2014	6/1/2014	N/A	N/A	N/A
NF-As	6/1/2011	7/1/2012	13	3/29/2013	24
		Payment Reduction Exempt Effective Date			
DP/NF-Bs					
Rural & Frontier	6/1/2011	9/1/2013	27	4/1/2015	66
Non Rural & Frontier	6/1/2011	10/1/2013	28	4/1/2015	66

4. The estimated savings due to the implementation of AB 97 payment reductions are:

		Total Fund		
		FY 2014-15	**FY 2015-16**	**Annual**
AB 1629 Facilities	FFS	$0	$0	$0
ICF/DDs	FFS	($5,413,000)	($5,413,000)	($5,413,000)
	FFS Retro	$0	$0	$0
	ICF/DDs Total	($5,413,000)	($5,413,000)	
NF-As	FFS	($254,000)	($254,000)	($254,000)
	FFS Retro	($92,000)	$0	$0
	NF-As Total	($346,000)	($254,000)	
DP/NF-Bs	FFS	$0	$0	$0
	FFS Retro	($3,793,000)	($15,170,000)	($15,170,000)
	DP/NF-Bs Total	($3,793,000)	($15,170,000)	
	Total FFS	($5,667,000)	($5,667,000)	($5,667,000)
	Total FFS Retro	($3,885,000)	($15,170,000)	($15,170,000)
	Total Managed Care	$0	$0	$0
Grand Total		**($9,552,000)**	**($20,837,000)**	

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

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	151
IMPLEMENTATION DATE:	1/2015
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1505

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$21,257,000	-$42,514,000
- STATE FUNDS	-$10,628,500	-$21,257,000
PAYMENT LAG	0.8318	0.9929
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$17,681,600	-$42,212,200
STATE FUNDS	-$8,840,790	-$21,106,080
FEDERAL FUNDS	-$8,840,790	-$21,106,080

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of a reduction to radiology rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010)

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rates with dates of service on or after October 1, 2010. Radiology rates in excess of this amount will be reduced. Due to delay in expected federal approval, a two-year retroactive application of this reduction could adversely impact access to needed radiology services. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% reduction, and that federal approval of a reduction with a lengthy retroactive recoupment is extremely unlikely, the effective date for retroactive savings shifted from October 1, 2010 to October 1, 2012.

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

- Implementation date change from July 2014 to January 2015 because of delay in federal approval.
- Updated prospective Medi-Cal rates for radiology services resulting in an increase in annual savings.

Methodology:

1. Implementation will begin in January 2015.

2. Rate reductions will be retroactive to October 1, 2012.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 151

3. The Medi-Cal rate reductions will apply to radiology services reimbursement rates exceeding 80% of 2012 Medicare rates. The weighted average reduction for rates above 80% of Medicare is 18%.

4. Assume annual fee-for-service (FFS) savings $21,333,000.

   FFS Monthly Savings:
   $21,333,000 ÷ 12 months = $1,777,750

5. There is no managed care impact as a result of this reduction because managed care capitation rates are calculated using radiology rates that are at or below 80% of Medicare rates.

6. The total recoupment of retroactive savings from October 1, 2012 to December 31, 2014 is estimated to be $48,000,000 and is expected to occur over 27 months beginning January 2015. Monthly recoupment amount is based on 5% cap of monthly radiology reimbursements.

   Total recoupment of retroactive savings:
   $21,333,000 ÷ 12 months x 27 months = $48,000,000
   Monthly recoupment amount is $1,765,000

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
2014-15 Savings	($10,666)	($5,333)	($5,333)
Recoupment of Retro Savings	($10,590)	($5,295)	($5,295)
Total*	**($21,257)**	**($10,628)**	**($10,628)**

FY 2015-16	**TF**	**GF**	**FF**
2015-16 Savings	($21,333)	($10,666)	($10,666)
Recoupment of Retro Savings	($21,181)	($10,590)	($10,590)
Total*	**($42,514)**	**($21,257)**	**($21,257)**

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

*Amounts may differ due to rounding.

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER:	152
IMPLEMENTATION DATE:	7/2013
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1708

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$194,990,000	-$194,990,000
- STATE FUNDS	-$97,495,000	-$97,495,000
PAYMENT LAG	0.8774	1.0000
% REFLECTED IN BASE	67.46 %	59.13 %
APPLIED TO BASE		
TOTAL FUNDS	-$55,670,800	-$79,692,400
STATE FUNDS	-$27,835,400	-$39,846,210
FEDERAL FUNDS	-$27,835,400	-$39,846,210

DESCRIPTION

Purpose:
This policy change estimates savings that will occur by implementing the Diagnosis Related Group (DRG) payment methodology for Medi-Cal inpatient services for private hospitals and Non-Designated Public Hospitals (NDPHs) and freezing rates at the July 1, 2013 level.

Authority:
SB 853 (Chapter 717, Statutes 2010), Welfare & Institutions Code 14105.28

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon DRGs. The DRG payment methodology replaces the previous payment methods.

Previously, private hospitals and NDPHs received reimbursement for Medi-Cal fee-for-service (FFS) acute inpatient services according to the negotiated per-diem rates under the Selective Provider Contracting Program (SPCP). Contract hospitals bill for some services carved-out of the per-diem charges separately. For non-contract hospitals, Medi-Cal reimburses FFS inpatient services with cost-based interim per-diem rates.

Under the previous payment system, these hospitals billed Medi-Cal the daily inpatient service charges on a per day usage. Providers received payment for the actual number of days a beneficiary remained in their care, and not on a diagnosis or treatment strategy basis.

On July 1, 2013, the Department transitioned private hospitals to a DRG payment system which correlates reimbursement to the Medi-Cal beneficiary's assigned DRG. DRG reimbursement is designed to treat all patients assigned to a specific DRG as having a similar clinical condition requiring similar interventions.

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 152

NDPHs continued to receive payments under the previous methodology through December 31, 2013. These hospitals transitioned to a DRG payment system on January 1, 2014.

In Medi-Cal managed care counties, the Department contracts with health plans to provide services, including inpatient services, to Medi-Cal beneficiaries enrolled in the plans. Each plan receives a per member per month capitation rate for enrolled beneficiaries. The DRG payment system froze base rates at the July 1, 2013 level which directly impacts managed care capitation rates.

Reason for Change from Prior Estimate:
The change is due to updated payment data.

Methodology:

1. The DRG payment methodology was implemented on July 1, 2013 for private hospitals.

2. The DRG payment methodology was implemented on January 1, 2014 for NDPHs.

3. Using the community inpatient service category base estimate, adjusted to remove Designated Public Hospital expenditures, and incorporating relative policy changes;
   - FY 2014-15 and FY 2015-16 expenditures under the prior methodology are estimated to be $3,355,883,000 TF for private hospitals and $176,625,000 TF for NDPHs.

4. FY 2014-15 and FY 2015-16 FFS payments under the DRG payment system are frozen at the July 1, 2013 level and are estimated to be $3,170,642,000 TF for private hospitals and $166,876,000 TF for NDPHs.

5. Private hospital FFS savings in FY 2014-15 and FY 2015-16 are estimated to be:

   $3,355,883,000 - $3,170,642,000 = $185,241,000 TF ($92,620,500 GF)

6. NDPH FFS savings in FY 2014-15 and FY 2015-16 are estimated to be:

   $176,625,000 - $166,876,000 = $9,749,000 TF ($4,874,500 GF)

The DRG savings are as follows:

(Dollars in Thousands)	TF	GF	FF
FY 2014-15 and FY 2015-16 Annual			
Private FFS	($185,241)	($92,621)	($92,620)
NDPH FFS	($9,749)	($4,875)	($4,874)
Total savings	**($194,990)**	**($97,496)**	**($97,494)**

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	12/2011
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1580

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$380,722,000	-$428,271,000
- STATE FUNDS	-$190,361,000	-$214,135,500
PAYMENT LAG	0.9963	0.9987
% REFLECTED IN BASE	49.07 %	49.54 %
APPLIED TO BASE		
TOTAL FUNDS	-$193,184,300	-$215,824,600
STATE FUNDS	-$96,592,140	-$107,912,300
FEDERAL FUNDS	-$96,592,140	-$107,912,300

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of the provider payment reduction pursuant to Assembly Bill (AB) 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
AB 97 requires the Department to implement up to a 10% provider payment reduction, which will affect all services except:

- Hospital inpatient and outpatient services, critical access hospital, federal rural referral centers,
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs),
- Services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs,
- Hospice services,
- Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services, and
- Payments funded by certified public expenditures and intergovernmental transfers.

Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5%. Other fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. A recent court decision vacated the preliminary injunctions clearing the way for the

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

Department to implement the payment reductions.

The actuarial equivalent of FFS payment reductions to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

Reason for Change from Prior Estimate:

- Delay in implementation due to system delays.
- Updated program expenditures.
- This policy change only includes the managed care payment reduction savings for primary care physicians. The managed care FY 2014-15 and FY 2015-16 capitation rates already incorporate the payment reduction except for primary care physicians.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes. The following services will not be subject to a reduction:
   - Pharmacy, and
   - Specialty physician services.

2. **FFS**: The Department implements the FFS payment reductions in three phases.

   - **Phase I**: Phase I includes all subject providers except for the previously enjoined providers and the Child Health and Disability Prevention (CHDP) program.

     - Pediatric Day Health Care (PDHC) program are exempt from the 10% payment reduction effective April 1, 2012. The Department stopped the 10% payment reduction on October 25, 2012. The refund for reduced payment for services on or after April 1, 2012 was made in July 2013.
     - The Department received CMS approval on August 28, 2013 to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012. The Department stopped the 10% payment reduction in November 2013 and will refund the payment reduction for the period October 19, 2012 through October 31, 2013 in September 2014.
     - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
     - Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and anticipates refunding the payment reduction for the period June 1, 2011 through November 30, 2013 in September 2014.
     - Community-Based Adult Services (CBAS) providers located in San Francisco will be exempt from the 10% payment reduction effective July 1, 2014.

   - **Phase II**: Phase II includes all the previously enjoined providers.

10% PROVIDER PAYMENT REDUCTION

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- Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 will be exempt from the 10% payment reduction effective August 31, 2013.
- For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 will be exempt from the 10% payment reduction effective December 1, 2013, pending the federal approval.
- Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions will be exempt from the 10% payment reduction effective March 31, 2012.

- **Phase III**: Phase III includes the CHDP program providers.

3. Due to access concerns, the Department will forgo the retroactive recoupments for the following providers:
   - Physicians,
   - Medical transportation,
   - Dental,
   - Clinics,
   - Certain high-cost drugs, and
   - CHDP.

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	1/10/2014	1/10/2014	N/A	N/A	N/A
Medical Transportation	9/5/2013	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	3/1/2015	63
Dental	9/5/2013	9/5/2013	N/A	N/A	N/A
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	3/1/2015	66
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

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4. The estimated savings from AB 97 payment reduction are:

(Dollars In Thousands)		FY 2014-15	Total Fund FY 2015-16	Annual
Phase I	FFS	($38,793)	($44,776)	($44,776)
	FFS Retro	$0	$0	$0
	Phase I Total	($38,793)	($44,776)	
Phase II				
Physicians	FFS	($49,746)	($49,746)	($49,746)
	FFS Retro	$0	$0	$0
Medical Transportations	FFS	($14,461)	($14,461)	($14,461)
	FFS Retro	$0	$0	$0
DME/Medical Supplies	FFS	($17,394)	($17,394)	($17,394)
	FFS Retro	($2,503)	($7,510)	($7,510)
Dental	FFS	($60,458)	($60,458)	($60,458)
	FFS Retro	$0	$0	$0
Clinics	FFS	($18,512)	($18,512)	($18,512)
	FFS Retro	$0	$0	$0
Pharmacy	FFS	($113,718)	($113,718)	($113,718)
	FFS Retro	($17,977)	($53,931)	($53,931)
	FFS	($274,289)	($274,289)	($274,289)
	FFS Retro	($20,480)	($61,441)	($61,441)
	Phase II Total	($294,769)	($335,730)	
Phase III (CHDP)	FFS	($1,811)	($2,414)	($2,414)
	FFS Retro	$0	$0	$0
	Phase III Total	($1,811)	($2,414)	
	FFS	($314,892)	($321,480)	($321,480)
	FFS Retro	($20,480)	($61,441)	($61,441)
	Managed Care	($45,350)	($45,350)	($45,350)
	Grand Total	**($380,722)**	**($428,271)**	($428,271)

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

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154
IMPLEMENTATION DATE: 1/2015
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1761

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$6,945,877,000	$7,547,970,000
- STATE FUNDS	$3,122,470,000	$3,410,589,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,945,877,000	$7,547,970,000
STATE FUNDS	$3,122,470,000	$3,410,589,000
FEDERAL FUNDS	$3,823,407,000	$4,137,381,000

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the extension of the quality assurance fee (QAF) program.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014 and anticipates SPA approval in FY 2014-15.

Reason for Change from Prior Estimate:
Federal approval is delayed, but the FY 2014-15 estimate is unchanged.

Methodology:
1. Per SB 239, the Hospital QAF program will be extended from January 1, 2014 through December 31, 2016.

2. The first Fee-For-Service payment is estimated to be made in January 2015. This includes designated public hospital and non-designated public hospital grant amounts.

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

3. The first managed care payment is estimated to be made in March 2015.

4. On a cash basis, the estimated QAF payments are:

(Dollars In Thousands)	TF	SF(HQARF)	FF Title 19	FF Title 21
FY 2014-15	**$6,945,877**	**$3,122,470**	**$3,798,184**	**$25,223**
FY 2015-16	**$7,547,970**	**$3,410,589**	**$4,085,915**	**$51,466**

Funding:
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	155
IMPLEMENTATION DATE:	9/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1475

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$628,134,000	$0
- STATE FUNDS	$365,696,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$628,134,000	$0
STATE FUNDS	$365,696,000	$0
FEDERAL FUNDS	$262,438,000	$0

DESCRIPTION

Purpose:
This policy change estimates the payments hospitals will receive from the quality assurance fee (QAF) program.

Authority:
AB 1383 (Chapter 627, Statutes of 2009)
AB 188 (Chapter 645, Statutes of 2009)
AB 1653 (Chapter 218, Statutes of 2010)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 920 (Chapter 452, Statutes of 2012)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
AB 1383 authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. AB 1653 revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 155

AB 188 established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 extended the Hospital QAF program for the period January 1, 2011 through June 30, 2011 based on a modified amount of payments to hospitals and an increased amount for children's health care coverage.

SB 335 extended the Hospital QAF program from July 1, 2011 through December 31, 2013. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SB 920:

- Modified the QAF calculation and installment payment provisions, supplemental amounts paid to private hospitals for inpatient services,
- Increased the NDPH aggregate grant amounts for each fiscal year, and
- Reduced the Low Income Health Program MCE Out-of-Network Emergency Care Services Fund (LIHP), and deleted NDPHs as recipients of money from the fund.

Reason for Change from Prior Estimate:

The changes are due to:

- Updated the availability of QAF fund for LIHP transfer, and
- The QAF I, II and III payments are less than previously scheduled.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. The first QAF program was effective April 1, 2009 through December 31, 2010 (QAF I); with a two-quarter extension through June 30, 2011 (QAF II). An additional 30-month QAF program is effective for the time period July 1, 2011 through December 31, 2013 (QAF III).

3. On an accrual basis, the QAF III program fee is expected to generate $4.3 billion in FY 2011-12, $4.5 billion in FY 2012-13, and $2.4 billion in FY 2013-14 in fee-for-service (FFS), managed care

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 155

capitation, grant payments and mental health payments.

4. First FFS payment of the QAF III program to the hospitals occurred in August 2012.
5. $15.9 million of the QAF I program mental health plan payments will be paid in FY 2014-15.
6. $697,000 of the QAF II program FFS payments will be paid in FY 2014-15.
7. $106.7 million of the QAF III program fees will be transferred to LIHP in FY 2014-15.
8. On a cash basis, payments to the hospitals are estimated to be:

	TF	SF(HQARF)	FF Title 19	FF Title 21	ARRA
FY 2014-15					
AB 1383**	$15,898,000	$6,106,000	$7,949,000	$0	$1,843,000
SB 90*	$697,000	$294,000	$349,000	$0	$55,000
SB 335**	$504,876,000	$252,633,000	$245,485,000	$6,759,000	$0
LIHP**	$106,663,000	$106,663,000	$0	$0	$0
Total***	**$628,134,000**	**$365,696,000**	**$253,783,000**	**$6,759,000**	**$1,898,000**

***Totals may differ due to rounding.

Funding:
Hospital Quality Assurance Revenue Fund (4260-610-3158)*
Hospital Quality Assurance Revenue Fund (4260-611-3158)**
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER:	156
IMPLEMENTATION DATE:	4/2014
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1661

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$222,242,000	$61,759,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$222,242,000	$61,759,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$222,242,000	$61,759,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers.

Authority:
AB 678 (Chapter 397, Statutes of 2011)

Interdependent Policy Changes
Not Applicable

Background:
A provider that delivers GEMT services to Medi-Cal beneficiaries will be eligible for supplemental payment for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the state, a city, county, city and county, federally recognized Indian tribe, health care district, special district, community services district, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program is retroactive to January 30, 2010. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) #09-024 on September 4, 2013. Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 156

Reason for Change from Prior Estimate:
The change is due to:

- The FY 2013-14 payment shifted to FY 2014-15 due to a delay in receipt of completed cost reports, and
- Updated program expenditures.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. Funding for services provided between January 30, 2010 through June 30, 2011 will be reimbursed at the appropriate FMAP rate.

3. Payments began in April 2014.

The estimated payments on a cash basis are:

(Dollars In Thousands) FY 2014-15		Total FFP	Regular FFP	ARRA	CPE
	FY 2009-10	$43,113	$35,000	$8,113	$70,000
	FY 2010-11	$47,022	$39,939	$7,083	$79,878
	FY 2011-12	$36,713	$36,713		$73,425
	FY 2012-13	$41,569	$41,569		$83,139
	FY 2013-14	$53,825	$53,825		$107,650
Total FY 2014-15*		**$222,242**	$207,046	$15,196	$414,092

FY 2015-16		Total FFP	Regular FFP	ARRA	CPE
	FY 2014-15	$61,759	$61,759		$123,518
Total FY 2015-16		**$61,759**	$61,759	$0	$123,518

*Total may differ due to rounding.

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

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 157
IMPLEMENTATION DATE: 7/1991
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 82

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$169,187,000	$97,148,000
- STATE FUNDS	$74,670,500	$38,670,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$169,187,000	$97,148,000
STATE FUNDS	$74,670,500	$38,670,000
FEDERAL FUNDS	$94,516,500	$58,478,000

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:
SB 1732 (Chapter 1635, Statutes of 1988)
SB 2665 (Chapter 1310, Statutes of 1990)
SB 1128 (Chapter 757, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals. The Selective Provider Contracting Program (SPCP) ended June 30, 2013 due to the implementation of the Diagnosis Related Group payment methodology. CMS approved State Plan Amendment (SPA) 13-011 on December 11, 2013, which maintains the Federal authority for SB 1732.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code. The Department claims federal funds using certified public expenditures from eligible DP-NFs.

Reason for Change from Prior Estimate:
The increase is due to a delay in payments. The Department is waiting for new Federal authority to make these payments.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 157

Methodology:

FY 2014-15	**TF**	**GF**	**FF**
Hospitals			
FY 2011-12	$360,000	$180,000	$180,000
FY 2012-13	$16,552,000	$8,276,000	$8,276,000
FY 2013-14	$54,198,000	$27,099,000	$27,099,000
FY 2014-15	$78,231,000	$39,115,000	$39,115,000
DP-NFs			
FY 2013-14	$19,846,000	$0	$19,846,000
Total FY 2014-15	**$169,187,000**	**$74,670,000**	**$94,516,000**

FY 2015-16	**TF**	**GF**	**FF**
Hospitals			
FY 2015-16	$77,339,000	$38,670,000	$38,670,000
DP-NFs			
FY 2015-16	$19,808,000	$0	$19,808,000
Total FY 2015-16	**$97,148,000**	**$38,670,000**	**$58,478,000**

Funding:
100% Title XIX (4260-101-0890)
50% Title XIX Capital Debt FFP / 50% GF (4260-102-0001/0890)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	158
IMPLEMENTATION DATE:	4/2004
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	78

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$165,486,000	$173,833,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$165,486,000	$173,833,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$165,486,000	$173,833,000

DESCRIPTION

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal beneficiaries.

Authority:
AB 915 (Chapter 747, Statutes of 2002)

Interdependent Policy Changes:
Not Applicable

Background:
AB 915 created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Publicly owned or operated hospitals now receive supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

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

- Revised caseload amounts for FY 2012-13 and FY 2013-14, and
- A delay in the FY 2003-04 Reconciliation.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level. The Department will apply the appropriate FMAP to the reconciliation.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 158

2. Payments of $156,101,000 are expected to be made in FY 2014-15 based on CPE claims for FY 2011-12 through FY 2013-14. Payments are adjusted for the change in the FMAP.

3. Payments of $164,433,000 are expected to be made in FY 2015-16 based on CPE claims. The reconciliation payments noted in Methodology #4 and 5 are not included in this amount.

4. The reconciliation mandated by AB 915 against audited cost reports will begin in FY 2014-15. Additional payments of $9,385,000 for service year 2002-03 are expected to be made in FY 2014-15 as a result of the reconciliation.

5. The reconciliation for FY 2003-04 is expected to be completed in FY 2015-16. Additional payments of $9,400,000 are expected to be made as a result of the reconciliation.

Estimated costs are as follows:

FY 2014-15	**TF**	**FFP**
FY 2002-03 (Reconciliation)	$9,385,000	$9,385,000
FY 2011-12	$830,000	$830,000
FY 2012-13	$1,842,000	$1,842,000
FY 2013-14	$153,429,000	$153,429,000
Total FY 2014-15	**$165,486,000**	$165,486,000

FY 2015-16	**TF**	**FFP**
FY 2003-04 (Reconciliation)	$9,400,000	$9,400,000
FY 2013-14 (Est. Adjustments)	$1,951,000	$1,951,000
FY 2014-15	$162,482,000	$162,482,000
Total FY 2015-16	**$173,833,000**	$173,833,000

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

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	159
IMPLEMENTATION DATE:	10/2013
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1600

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$140,000,000	$70,000,000
- STATE FUNDS	$70,000,000	$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$140,000,000	$70,000,000
STATE FUNDS	$70,000,000	$35,000,000
FEDERAL FUNDS	$70,000,000	$35,000,000

DESCRIPTION

Purpose:
This policy change estimates the revenue and payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:
AB 113 (Chapter 20, Statutes of 2011)

Interdependent Policy Changes:
Not Applicable

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset General Fund (GF) costs of Medi-Cal children's health services.

Reason for Change from Prior Estimate:
The FY 2013-14 payment is delayed and expected to be paid out in FY 2014-15.

Methodology:
1. The NDPH IGT supplemental payments program is a formula-based program which depends on the UPL's available room. The available room is then applied to the formula to determine the supplemental payments, the administrative costs of operating the program, and the benefit of Medi-Cal's children's health programs.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159

2. The estimated NDPH IGT supplemental payments are:

(Dollars in Thousands)	TF	GF**	IGT*	FF
FY 2014-15				
FY 2013-14 Payments to NDPHs	$70,000	$0	$35,000	$35,000
FY 2013-14 Children's Services	$0	($3,322)	$3,322	$0
FY 2014-15 Payments to NDPHs	$70,000	$0	$35,000	$35,000
FY 2014-15 Children's Services	$0	($3,322)	$3,322	$0
Total FY 2014-15	**$140,000**	**($6,644)**	**$76,644**	**$70,000**
FY 2015-16				
FY 2015-16 Payments to NDPHs	$70,000	$0	$35,000	$35,000
FY 2015-16 Children's Services	$0	($3,322)	$3,322	$0
Total FY 2015-16	**$70,000**	**($3,322)**	**$38,322**	**$35,000**

Funding:
50% Title XIX /50% SB 1100 DPH DSH IGT (4260-606-0834/4260-101-0890)*
100% GF (4260-101-0001)**

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER:	160
IMPLEMENTATION DATE:	2/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	104

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$103,600,000	$80,200,000
- STATE FUNDS	$51,800,000	$40,100,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$103,600,000	$80,200,000
STATE FUNDS	$51,800,000	$40,100,000
FEDERAL FUNDS	$51,800,000	$40,100,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare & Institutions Code, Sections 14164 and 14087.3

Interdependent Policy Changes:
Not Applicable

Background:
This program allows Los Angeles and Alameda Counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:
The change is due to the addition of FY 2013-14 IGTs.

Methodology:
1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

(Dollars in Thousands)

FY 2014-15	TF	Special Deposit Fund	FFP
FY 2013-14	$48,200	$24,100	$24,100
FY 2014-15	$55,400	$27,700	$27,700
Total FY 2014-15	**$103,600**	**$51,800**	**$51,800**

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 160

(Dollars in Thousands)

FY 2015-16	TF	Special Deposit Fund	FFP
FY 2015-16	$80,200	$40,100	$40,100
Total FY 2015-16	**$80,200**	**$40,100**	**$40,100**

Funding Table:
50% Local Trauma Centers Fund / 50% Title XIX FFP (4260-601-0942142) / (4260-101-0890)

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER:	161
IMPLEMENTATION DATE:	6/2002
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	86

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$95,488,000	$46,924,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$95,488,000	$46,924,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$95,488,000	$46,924,000

DESCRIPTION

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals.

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

Interdependent Policy Changes:
Not Applicable

Background:
This program is designed to allow DP-NFs to claim FFP on the difference between their actual costs and the amount Medi-Cal currently pays under the existing program. The acute care hospital must be owned and operated by a public entity, such as a city, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal Beneficiaries.

AB 97 (Chapter 3, Statutes of 2011) authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services DP-NFs Level B providers render on or after June 1, 2011.

The Department received CMS approval on December 20, 2013 to prospectively exempt DP-NF Level B providers from the 10% payment reduction effective September 1, 2013 for providers located in designated rural and frontier areas. The remaining DP-NF Level B providers are exempt from the 10% payment reduction effective October 1, 2013.

Reason for Change from Prior Estimate:
AB 97 related payments are delayed and expected to be paid in FY 2014-15.

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2014-15 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

3. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Scheduled interim payments and reconciliation payments are represented below.

4. The AB 97 payment reduction/freeze will increase the uncompensated costs eligible for supplemental reimbursement under this program. The increased payments due to AB 97 payment reduction/rate freeze will be made in FY 2014-15.

5. Based on a funding of historical data and AB 97 rate reduction calculations, an estimate of $95,488,000 FFP and $46,924,000 FFP will be available in FY 2014-15 and FY 2015-16, respectively.

FY 2014-15	**Total FFP**	**FFP**	**ARRA**
FY 2008-09 Reconciliation	$2,113,000	$1,800,000	$313,000
FY 2013-14	$42,772,000	$42,772,000	
AB 97 Adjustments			
FY 2010-11	$9,391,000	$9,200,000	$191,000
FY 2011-12	$22,107,000	$22,107,000	
FY 2012-13	$19,105,000	$19,105,000	
Total FY 2014-15	**$95,488,000**	$94,984,000	$504,000

FY 2015-16	**Total FFP**	**FFP**	**ARRA**
FY 2009-10 Reconciliation	$2,398,000	$1,946,000	$452,000
FY 2014-15	$44,526,000	$44,526,000	
Total FY 2015-16	**$46,924,000**	$46,472,000	$452,000

Funding:

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

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER:	162
IMPLEMENTATION DATE:	7/2006
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1158

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$15,000,000	$15,000,000
- STATE FUNDS	$7,500,000	$7,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$15,000,000	$15,000,000
STATE FUNDS	$7,500,000	$7,500,000
FEDERAL FUNDS	$7,500,000	$7,500,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to non-SB 1100 hospitals.

Authority:
Welfare & Institutions Code 14164

Interdependent Policy Changes
Not Applicable

Background:
The Welfare & Institutions Code provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program.

This policy change provides authority to accept the IGTs from counties or health care districts, match them with federal funds, and distribute the funds to hospitals designated by the counties or health care districts for the purpose of supporting hospitals serving Medi-Cal beneficiaries.

This policy change is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under the Welfare & Institutions Code, section 14166.12.

The Selective Provider Contracting Program ended in June 2013. As part of the Private Hospital Supplemental Fund, the Centers for Medicare and Medicaid (CMS) approved a State Plan Amendment (SPA) on December 11, 2013 for the transition year 2013-14. The Department will be submitting a SPA to CMS in FY 2014-15 to continue IGT distributions to eligible private hospitals.

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

IGT PAYMENTS FOR HOSPITAL SERVICES

REGULAR POLICY CHANGE NUMBER: 162

Methodology:

1. Annual IGTs on an accrual basis are estimated to be $15,000,000. Cash basis payments vary from year-to-year based on when the IGTs are actually received.

(Dollars In Thousands)	TF	IGT	FFP
FY 2014-15	**$15,000**	**$7,500**	**$7,500**

	TF	IGT	FFP
FY 2015-16	**$15,000**	**$7,500**	**$7,500**

Funding:

50% Reimbursement GF / 50% Title XIX (4260-610-0995 / 4260-101-0890)

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	163
IMPLEMENTATION DATE:	5/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1140

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$11,813,000	$159,938,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,813,000	$159,938,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$11,813,000	$159,938,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to freestanding, non-hospital based clinics.

Authority:
AB 959 (Chapter 162, Statutes of 2006), Welfare & Institutions Code 14105.965

Interdependent Policy Change:
Not Applicable

Background:
Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down federal financial participation (FFP) is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities.

The State Plan Amendment (SPA) for this program was approved on August 8, 2012. Supplemental payments to freestanding, non-hospital based clinics will be retroactive to October 14, 2006. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the completion of audited cost reports.

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

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 163

additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. Supplemental payments for freestanding, non-hospital based clinics are expected to begin May 2015.

3. 25% of FY 2006-07 supplemental payments will be paid in FY 2014-15. The remaining 75% will be paid in FY 2015-16.

4. Annual supplemental payments to freestanding, non-hospital based clinics are expected to total between $47,000,000 and $75,000,000.

5. Supplemental payments are paid after the completion of cost report audits.

Program payment amounts are estimated to be:

(Dollars in Thousands)

FY 2014-15	**TF**	**ARRA**	**FFP**
FY 2006-07	$11,813		$11,813
Total FY 2014-15	**$11,813**	$0	$11,813

FY 2015-16	**TF**	**ARRA**	**FFP**
FY 2006-07	$35,438		$35,438
FY 2007-08	$61,500		$61,500
FY 2008-09	$63,000	$5,928	$57,072
Total FY 2014-15	**$159,938**	$5,928	$154,010

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 164
IMPLEMENTATION DATE: 1/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1038

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$10,000,000	$10,000,000
- STATE FUNDS	$5,000,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$10,000,000	$10,000,000
STATE FUNDS	$5,000,000	$5,000,000
FEDERAL FUNDS	$5,000,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:
Not Applicable

Background:
SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements for disproportionate share of outpatient services are $10,000,000 TF ($5,000,000 GF).

(Dollars in Thousands)

	TF	FF	GF
FY 2014-15	**$10,000**	**$5,000**	**$5,000**
FY 2015-16	**$10,000**	**$5,000**	**$5,000**

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 164

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 165
IMPLEMENTATION DATE: 1/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1039

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$8,000,000	$8,000,000
- STATE FUNDS	$4,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,000,000	$8,000,000
STATE FUNDS	$4,000,000	$4,000,000
FEDERAL FUNDS	$4,000,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:
Not Applicable

Background:
This program provides SRHs with increased reimbursement rates. The Department reimburses eligible providers on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

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

Methodology:
1. Assume annual reimbursements to SRHs providing outpatient services are $8,000,000 TF ($4,000,000 GF).

(Dollars in Thousands)

	TF	FF	GF
FY 2014-15	**$8,000**	**$4,000**	**$4,000**
FY 2015-16	**$8,000**	**$4,000**	**$4,000**

Funding:

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 165

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

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER:	166
IMPLEMENTATION DATE:	12/2010
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1616

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$4,000,000	$3,600,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,000,000	$3,600,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$4,000,000	$3,600,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)

Interdependent Policy Changes:
Not Applicable

Background:
Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. The Department certifies expenditures reported in facilities' cost report before claiming FFP.

Reasons for Change from Prior Estimate:
The change is due to updated data.

Methodology:
Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 166

Program payment amounts are estimated to be:

(Dollars In Thousands)

FY 2014-15	**FFP**
State Veterans' Homes for FY 2013-14	$2,250
State Veterans' Homes for FY 2014-15	$1,750
Total	**$4,000**

FY 2015-16	
State Veterans' Homes for FY 2014-15	$1,750
State Veterans' Homes for FY 2015-16	$1,850
Total	**$3,600**

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	173
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1488

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$217,513,000	$114,822,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$217,513,000	$114,822,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$217,513,000	$114,822,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade (AIU) and meaningfully use (MU) Electronic Health records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:
ARRA of 2009
SB 945 (Chapter 433, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The HITECH Act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must AIU and MU certified EHR technology in accordance with the HITECH Act. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department plans to expand the current Medicaid Management Information Systems (MMIS) to integrate a State Level Registry (SLR) payment functionality, allowing for more seamless and efficient participation and payment for eligible providers. The payments are intended to accelerate AIU and encourage MU of the EHR technology by providers serving the Medi-Cal population. It is estimated that approximately 20,000 to 22,000 providers, and 400 hospitals, will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal financial participation (FFP).

The Medi-Cal Fiscal Intermediary (FI) is implementing the SLR, a system necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive Program.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 173

System costs are budgeted in the FI Estimate. Administrative costs for the State's Health Information Technology (HIT) program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Reason for Change from Prior Estimate:
The expected incentive payment costs to providers have been adjusted and are based on actual expenditures.

Methodology:

1. Payments to the providers began in December 2011.

2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.

3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is $21,250. Incentive payments for years two through six are $8,500 per eligible year. The maximum incentive payment for a professional over the six year period is $63,750.

4. Assume the aggregate hospital incentive payment amount is computed on a $2,000,000 base amount adjusted up or down depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. The years do not have to be consecutive. Payments will be limited to 50% of the aggregate hospital incentive payment for the first eligibility year, 30% for the second eligibility year and 10% for the third and fourth payment eligibility years.

5. Assume for FY 2014-15 and FY 2015-16, the aggregate hospital incentive payment is $3,000,000. The first year eligibility incentive payment will average $1,500,000, the second year eligible incentive payment will average $900,000, and the third and fourth year eligibility incentive payments will average $300,000.

6. The estimated payments for FY 2014-15 and FY 2015-16 are based on a cash-basis. The estimate for FY 2014-15 includes actual payments up to July 2014.

(Dollars in thousands)

FY 2014-15		**FF**
2,000 professionals x $21,250 = $42,500,000	Eligibility Year 1 Professional Payments	$42,500
3,149 professionals x $8,500 = $26,766,500	Eligibility Year 2 Professional Payments	$26,767
1,056 professionals x $8,500 = $8,976,000	Eligibility Year 3-4 Professional Payments	$8,976
220 professionals x $8,500 = $1,870,000	Eligibility Year 4 Professional Payments	$1,870
30 hospitals x $1,500,000 = $45,000,000	Eligibility Year 1 Hospital Payments	$45,000
59 hospitals x $900,000 =$53,100,000	Eligibility Year 2 Hospital Payments	$53,100
90 hospitals x $300,000 = $27,000,000	Eligibility Year 3-4 Hospital Payments	$27,000
41 hospitals x $300,000 = $12,300,000	Eligibility Year 4 Hospital Payments	$12,300
FY 2014-15 Total		**$217,513**

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 173

(Dollars in thousands)

FY 2015-16		FF
1,024 professionals x $21,250 = $21,760,000	Eligibility Year 1 Professional Payments	$21,760
2,884 professionals x $8,500 = $24,514,000	Eligibility Year 2 Professional Payments	$24,514
1,147 professionals x $8,500 = $9,749,500	Eligibility Year 3 Professional Payments	$9,750
388 professionals x $8,500 = $3,298,000	Eligibility Year 4 Professional Payments	$3,298
2 hospitals x $1,500,000 = $3,000,000	Eligibility Year 1 Hospital Payments	$3,000
18 hospitals x $900,000 = $16,200,000	Eligibility Year 2 Hospital Payments	$16,200
68 hospitals x $300,000 = $20,400,000	Eligibility Year 3 Hospital Payments	$20,400
53 hospitals x $300,000 = $15,900,000	Eligibility Year 4 Hospital Payments	$15,900
FY 2015-16 Total		**$114,822**

Funding:

100% FFP (4260-101-0890)

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER:	175
IMPLEMENTATION DATE:	6/2011
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1232

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$114,643,000	$122,158,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$114,643,000	$122,158,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$114,643,000	$122,158,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries for the California Department of Developmental Services (CDDS).

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
Beneficiaries that reside in ICF-DDs receive active treatment services from providers located off-site from the ICF-DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.

On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD beneficiaries. CMS approved reimbursement for these costs retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2014-15 and FY 2015-16. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 175

Reason for Change from Prior Estimate:
Updated expenditures reflect that prior year billings and ARRA payments will be complete by FY 2015-16.

Methodology:
The following estimates have been provided by CDDS:

(In Thousands)

CASH BASIS	TF	CDDS GF	FFP Regular	FFP ARRA	Total* FFP	IA #
FY 2014-15	$217,358	$102,715	$108,679	$5,964	**$114,643**	07-65896
FY 2015-16	$232,389	$110,231	$116,194	$5,964	**$122,158**	07-65896

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

*Amounts may differ due to rounding.

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	176
IMPLEMENTATION DATE:	7/2008
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1340

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$68,216,000	$66,980,000
- STATE FUNDS	$34,108,000	$33,490,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$68,216,000	$66,980,000
STATE FUNDS	$34,108,000	$33,490,000
FEDERAL FUNDS	$34,108,000	$33,490,000

DESCRIPTION

Purpose:
This policy change estimates the noncontract hospital inpatient cost settlements.

Authority:
Welfare & Institutions (W&I) Code 14170

Interdependent Policy Changes:
Not Applicable

Background:
All noncontract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the noncontract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.

Beginning July 1, 2013, with the implementation of the Diagnosis Related Group (DRG) hospital inpatient payment methodology, the Selective Provider Contracting Program (SPCP) contract and noncontract hospital per diem rate methodology was discontinued for private hospitals. Non-Designated Public Hospitals (NDPHs) transitioned to the DRG reimbursement methodology on January 1, 2014. Although the contract and noncontract hospital designations are eliminated under the DRG, noncontract hospital inpatient cost settlements for dates prior to the DRG implementation will continue as required by W&I Code 14170.

Reason for Change from Prior Estimate:
The changes are due to updated expenditure data.

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 176

Methodology:

1. Payments for noncontract hospital inpatient cost settlements made in FY 2013-14 totaled $63.2 million TF.

2. Based upon payments made through August 2014, noncontract hospital cost settlements are estimated to total $68,216,000 in FY 2014-15 and $66,980,000 in FY 2015-16.

(Dollars in Thousands)	TF	GF	FF
FY 2014-15	**$68,216**	**$34,108**	**$34,108**
FY 2015-16	**$66,980**	**$33,490**	**$33,490**

Funding:

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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER:	180
IMPLEMENTATION DATE:	9/2013
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	110

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$33,206,000	$0
- STATE FUNDS	$33,206,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$33,206,000	$0
STATE FUNDS	$33,206,000	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:
Public Law 95-452

Interdependent Policy Changes:
Not Applicable

Background:
The Department reached audit settlements with the Office of Inspector General (OIG):

- Federal audits: A-09-13-02012, A-09-13-02019, A-09-13-02044, and A-09-13-02047 regarding family planning services provided by the Family Planning Access, Care and Treatment (FPACT) program. The OIG found several claims that were not eligible for the claimed 90% federal Medicaid reimbursement for family planning services. The majority of claims were ineligible for reimbursement due to the primary purpose of the beneficiary's visit was not family planning.
- Federal audit A-09-12-02077 regarding drug and supplies provided by the FPACT program. The OIG found several claims were not eligible for the claimed 90% federal Medicaid reimbursement for family planning services. The majority of the claims were ineligible for reimbursement due to the primary purpose of the visit was not family planning.
- Federal audit A-09-12-02083 regarding unallowable Medi-Cal payments for items and services furnished, ordered, or prescribed by excluded providers. The OIG found Medi-Cal payments made to excluded providers that were not eligible for FFP.
- Federal audits 09-FS-2010-CA-01 and A-09-11-15988 regarding timesheets that did not meet the requirements or did not have the correct documentation.
- Federal audit A-09-12-02047 regarding credit balances. OIG found credit balances with Medi-Cal providers. These claims contained overpayments to providers.
- Federal audits A-09-08-00034, A-09-10-02006, A-09-11-02016, A-09-13-22211, and A-09-13-02028 evaluated the effectiveness of the Department's internal controls related to preventing or

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 180

detecting material noncompliance with laws, regulations, contracts and grants applicable to each of the federal programs.

- Federal audits A-09-10-13500 and A-09-09-00055 regarding claimed drug products not listed on the quarterly drug tapes and conclusive evidence that the drugs were eligible was not provided.

Reason for Change from Prior Estimate:
There are additional audit settlements to be paid in FY 2014-15.

Methodology:

1. The Federal audit A-09-13-02012 identified claims within Central Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $2,953,936 FFP to CMS in FY 2014-15.

2. The Federal audit A-09-13-02019 identified claims within East Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $4,049,335 FFP to CMS in FY 2014-15.

3. The Federal audit A-09-13-02044 identified claims within Central Los Angeles County where the beneficiary's primary purpose was not family planning. The Department will return $2,280,044 FFP to CMS in FY 2014-15.

4. The Federal audit A-09-12-02077 identified drug and supplies where the beneficiary's primary purpose was not family planning. The Department will return $627,000 FFP to CMS in FY 2014-15.

5. The Federal audit A-09-08-00034 identified Food and Drug Administration (FDA) approved drugs that should have been on the quarterly CMS records. The Department will return $1,341,000 to CMS in FY 2014-15.

6. The Federal audit A-09-10-13500 identified claims that were not necessary and contracts were provided for but did not meet the federal requirements for the program. The Department will return $101,000 CMS in FY 2014-15.

7. The Federal Audit A-09-09-00055 identified manual claims for compound drug expenditures that were not properly identified. The Department will return $1,096,464 to CMS in FY 2014-15.

8. The Federal Audit A-09-10-02006 identified electronic claims for compound drug expenditures that were not properly identified. The Department will return $13,566,000 to CMS in FY 2014-15.

9. The Federal Audit A-09-11-15988 identified claims that were identified in the incorrect fiscal quarters. The Department will return $9,000 to CMS in FY 2014-15.

10. The Federal Audit A-09-11-02016 identified unallowable Medicaid payments for items and services by excluded providers. The Department will return $140,000 to CMS in FY 2014-15.

11. The Federal Audit A-09-13-22211 identified managed care claims that were not allowed because of incorrect eligibility of recipients. The Department will return $10,000 to CMS in FY 2014-15.

12. The Federal Audit A-09-12-02047 identified Medicaid overpayments from non-institutional providers. The Department will return $619,000 to CMS in FY 2014-15.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 180

13. The Federal Audit A-09-13-02028 identified The Department's rates for standard power wheelchairs, oxygen systems and concentrators were significantly lower than Medicare's payment rates. The Department will return $3,879,000 to CMS in FY 2014-15.

14. The Federal Audit 09-FS-2010-CA-01 identified timesheets that did not have adequate documentation. The Department will return $1,000 to CMS in FY 2014-15.

15. The Federal Audit A-09-12-02083 identified nonemergency medical transportation services that did not comply with Federal and State requirements. The Department will return $266,000 to CMS in FY 2014-15.

16. The Federal Audit A-09-13-02047 identified claim records that did not comply with Federal requirements for family planning services. The Department will return $2,668,000 to CMS in FY 2014-15.

FY 2014-15		**TF**	**GF**
A-09-12-02077	FPACT-Drugs Review	$627,000	$627,000
A-09-13-02012	FPACT-Services, Central Los Angeles	$2,954,000	$2,954,000
A-09-13-02019	FPACT-Services, East Los Angeles	$4,049,000	$4,049,000
A-09-13-02044	FPACT-Services, Orange County	$2,280,000	$2,280,000
A-09-08-00034	Medicaid Compound Drug Expenditures	$1,341,000	$1,341,000
A-09-10-13500	KPMG Claims	$101,000	$101,000
A-09-09-00055	Medicaid Compound Drug Manual Claims	$1,096,000	$1,096,000
A-09-10-02006	Medicaid Compound Drug Electronic Claims	$13,566,000	$13,566,000
A-09-11-15988	Timesheets for IHSS	$9,000	$9,000
A-09-13-22211	Managed Care Claims	$10,000	$10,000
09-FS-2010-CA-01	In-Home Services Documentation	$1,000	$1,000
A-09-12-02083	Reimbursement for Medical Transportation	$266,000	$266,000
A-09-13-02047	FPACT-Improper Claim Federal Reimbursement	$2,268,000	$2,268,000
A-09-11-02016	OIG Excluded Providers	$140,000	$140,000
A-09-12-02047	OIG additional Credit Balance Recovery	$619,000	$619,000
A-09-13-02028	Durable Medical Equipment Competitive Bid Program	$3,879,000	$3,879,000
	Total	**$33,206,000**	**$33,206,000**

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

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER:	181
IMPLEMENTATION DATE:	7/2010
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1526

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$16,415,000	$16,415,000
- STATE FUNDS	$6,481,000	$6,481,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$16,415,000	$16,415,000
STATE FUNDS	$6,481,000	$6,481,000
FEDERAL FUNDS	$9,934,000	$9,934,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and the costs of the increased rates due to the Quality Assurance Fee.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
The CDDS makes supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, the Centers for Medicare and Medicaid Services approved a State Plan Amendment (SPA) for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs, so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2014-15 and FY 2015-16. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 181

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDS.

Reason for Change from Prior Estimate:
Updated expenditures reflect that prior year billings and ARRA payments will be complete by FY 2015-16.

Methodology:
The following estimates have been provided by CDDS:

FY 2014-15* (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$1,500	$8,322	$18,116	$1,702	**$6,481**	**$9,934**

FY 2015-16* (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursements	Total Funds	CDDS GF	DHCS GF	FFP
$1,500	$8,322	$18,116	$1,702	**$6,481**	**$9,934**

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

*Actuals may differ due to rounding.

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER: 182
IMPLEMENTATION DATE: 10/2014
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1826

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$11,734,000	$0
- STATE FUNDS	$3,520,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$11,734,000	$0
STATE FUNDS	$3,520,000	$0
FEDERAL FUNDS	$8,214,000	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement to Indian Health Services/Memorandum of Agreement 638 (IHS/MOA 638) clinics for services provided to Medicare/Medi-Cal crossover beneficiaries.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
Tribal health programs can elect to participate in Medi-Cal as IHS/MOA 638 providers and receive a federally established annual rate for Medi-Cal visits.

IHS/MOA 638 clinics did not receive the full federal per visit rate for services provided to Medi-Cal Crossover beneficiaries between calendar years (CYs) 2009 through 2012. The Department did not disperse the full amount of the Medicare and/or Medi-Cal payment for the billed procedure code 02. IHS/MOA 638 clinics were not required to provide the annual reconciliation reports during that time period. Due to the expansion of the Medi-Cal Managed Care program to all counties, IHS/MOA 638 clinics are now required to submit the reconciliation reports to the Department. The Department has made the proper payment adjustments for claims after CY 2012.

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

- FY 2013-14 costs shifted to FY 2014-15 due to delay in processing the reconciliation applications.
- Audits of the reconciliation reports show a lower than anticipated Medicare reimbursements, therefore increasing Medi-Cal amounts that was underpaid for CYs 2009 through 2012.

REIMBURSEMENT FOR IHS/MOA 638 CLINICS

REGULAR POLICY CHANGE NUMBER: 182

Methodology:

1. Assume a total of $11,734,456 was underpaid to 50 IHS/MOA 638 clinics for services rendered to crossover beneficiaries from CYs 2009 through 2012.

2. $4,693,782, or 40% of the $11,734,456, is estimated to be eligible for 100% Federal Medical Assistance Percentage (FMAP). This estimate was based on a paid claims report where 40% of the beneficiaries were American Indians.

3. The remaining $7,040,674 will be funded at a regular 50% FMAP.

4. Reconciliation payments are to be made in FY 2014-15.

FY 2014-15	TF	GF	FF
FY 2008-09	$1,476,000	$443,000	$1,033,000
FY 2009-10	$2,988,000	$896,000	$2,092,000
FY 2010-11	$2,946,000	$884,000	$2,062,000
FY 2011-12	$2,874,000	$862,000	$2,012,000
FY 2012-13	$1,449,000	$435,000	$1,014,000
Total*	**$11,734,000**	**$3,520,000**	**$8,214,000**

*Totals may differ due to rounding.

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

OVERTIME FOR IHSS PROVIDERS

REGULAR POLICY CHANGE NUMBER:	184
IMPLEMENTATION DATE:	7/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1852

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$4,000,000	$4,000,000
- STATE FUNDS	$2,000,000	$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,000,000	$4,000,000
STATE FUNDS	$2,000,000	$2,000,000
FEDERAL FUNDS	$2,000,000	$2,000,000

DESCRIPTION

Purpose:
This policy change estimates the cost of paying In-Home Supportive Services (IHSS) providers, related to Waiver Personal Care Services (WPCS), overtime and travel time.

Authority:
Welfare & Institutions Code, Section 12300.4

Interdependent Policy Changes:
Not Applicable

Background:
New federal regulations require IHSS employees to be paid overtime. Therefore, there will be additional costs for the Department related to the WPCS policy change. The Welfare & Institutions Code, Section 12300.4 identifies two additional costs to the IHSS Program. These new areas include overtime and travel time for IHSS providers. Based on statute, an IHSS provider cannot exceed 66 hours in a workweek: a 40 hour workweek and 26 hours of overtime. Travel time is defined as time spent traveling directly from a location where authorized services are provided to one recipient, to another location where authorized services are to be provided to another recipient.

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

Methodology:
1) Estimated IHSS costs for overtime and travel time are $4,000,000 TF in FYs 2014-15 and 2015-16.

2) While the Governor's Budget includes funding to implement Federal Labor Regulations regarding overtime, effective January 1, 2015, implementation of these regulations has been delayed until January 15, 2015, pending a federal court hearing.

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

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER:	186
IMPLEMENTATION DATE:	2/2012
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1629

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,016,000	$2,016,000
- STATE FUNDS	$2,016,000	$2,016,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,016,000	$2,016,000
STATE FUNDS	$2,016,000	$2,016,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Developmental Services (CDDS) to pay claims for CDDS consumers whose dental services are no longer covered by Medi-Cal.

Authority:
Interagency Agreement (IA) 10-87244

Interdependent Policy Changes:
Not Applicable

Background:
The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal no longer covered most dental services for adults 21 years of age and older, CDDS entered into an IA with the Department to have the Medi-Cal dental Fiscal Intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of claims processing and benefits will be reimbursed by CDDS. Processing of CDDS claims started on January 12, 2012. Select adult optional dental services were reinstated May 1, 2014.

This policy change estimates the reimbursement of benefit costs. The reimbursement of administration costs is budgeted in the Other Administration CDDS Dental Services policy change.

Reason for Change from Prior Estimate:
Expenditures have decreased because with the restoration of select optional adult dental services through Medi-Cal, CDDS is now responsible for fewer services.

Methodology:
1. Reimbursements began in February 2012.

2. Assume the benefit costs will be $2,016,000 annually.

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 186

Funding:
Reimbursement GF (4260-610-0995)

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER:	188
IMPLEMENTATION DATE:	4/1998
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	111

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,158,000	$2,317,000
- STATE FUNDS	-$10,616,500	-$10,616,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,158,000	$2,317,000
STATE FUNDS	-$10,616,500	-$10,616,500
FEDERAL FUNDS	$11,774,500	$12,933,500

DESCRIPTION

Purpose:
This policy change estimates the annual rate change posted in the Federal Register and the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to Native Americans eligible for Medi-Cal.

Authority:
Public Law 93-638

Interdependent Policy Changes:
Not Applicable

Background:
The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP for payments made by the State for services rendered to Native Americans through IHS tribal facilities.

Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

The per visit rate payable to the Indian Health Clinics is adjusted annually through changes posted in the *Federal Register*. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

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

- Rate change for CY 2014 and projected rate change for CY 2015
- Change in the number of Indian Health Clinics participating in Medi-Cal
- Updated annual cost for FY 2013-14

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 188

Methodology:

1. Currently, there are 54 Indian health clinics participating in Medi-Cal.

2. In FY 2013-14, the Department spent $21,233,000.

3. Recent changes posted in the Federal Register, Volume 79, Number 67, April 8, 2014 updated the per visit rate payable to Indian Health Clinics. Effective calendar year 2014, the per visit rate payable to Indian Health Clinics increased $12; from $330 to $342.

4. The FY 2014-15 estimate includes an additional $386,063 due to the increased rate for the period of January 2014 through June 2014. The annual rate increase for the additional $12 is $772,125.

5. The FY 2015-16 estimate includes an additional $514,750 due to the anticipated rate increase to $358 from $342 for the period of January 2015 through June 2015. This $16 annual rate increase is based on a five year average and is expected to cost an additional $1,029,500.

	FY 2014-15	FY 2015-16
CY 2014 rate increase	$772,000	$772,000
CY 2015 rate increase	$0	$1,030,000
Retro Jan –June 2014 rate increase	$386,000	$0
Retro Jan –June 2015 rate increase	$0	$515,000
Total Rate increase	$1,158,000	$2,317,000
FY 2013-14 Base expenditures	$21,233,000	$21,233,000
Total expenditures	$22,391,000	$23,550,000

Funding:

(Dollars In Thousands)

FY 2014-15		**TF**	**GF**	**FFP**
50% Title XIX FFP/ 50% GF	4260-101-0001/0890	($21,233)	($10,617)	($10,617)
100% Title XIX FFP	4260-101-0890	$22,391	$0	$22,391
Net Impact*		**$1,158**	**($10,617)**	**$11,775**

FY 2015-2016		**TF**	**GF**	**FFP**
50% Title XIX FFP / 50% GF	4260-101-0001/0890	($21,233)	($10,617)	($10,617)
100% Title XIX FFP	4260-101-0890	$23,550	$0	$23,550
Net Impact*		**$2,317**	**($10,617)**	**$12,934**

*Totals may differ due to rounding.

HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

REGULAR POLICY CHANGE NUMBER:	189
IMPLEMENTATION DATE:	7/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1843

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$209,000	$325,000
- STATE FUNDS	$104,500	$162,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$209,000	$325,000
STATE FUNDS	$104,500	$162,500
FEDERAL FUNDS	$104,500	$162,500

DESCRIPTION

Purpose:
This policy change estimates the costs associated with increasing rates for Homemaker Services provided under the AIDS Medi-Cal Waiver.

Authority:
AB 10 (Chapter 351, Statutes of 2013)
Section 1182.12 of the Labor Code

Interdependent Policy Changes:
Not Applicable

Background:
Local agencies, under contract with the California Department of Public Health's Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization. Homemaker services are a benefit provided to eligible clients under the AIDS Medi-Cal Waiver.

Homemaker services consist of general household activities performed when an individual who would otherwise be responsible for these activities is temporarily absent or unable to manage the home, care for themselves or others in the home. These services allow AIDS Medi-Cal Waiver participants, whose level of need is greater than others who receive only State Plan attendant services, to continue to live in an independent setting. Services rendered are in addition to, not in place of, services authorized under In-Home Supportive Services.

Reimbursement rates for homemaker services under the AIDS Medi-Cal Waiver have not increased since 2008. Subsequently, pursuant to AB 10 (Chapter 351, Statutes of 2013), the minimum wage increased to $9.00 per hour, effective July 1, 2014 and will increase to $10.00 per hour, effective January 1, 2016. The prior minimum wage was $8.00 per hour.

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

HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER

REGULAR POLICY CHANGE NUMBER: 189

Methodology:

1. Assume 794 beneficiaries in FY 2014-15 and 824 beneficiaries in FY 2015-16 use Homemaker Services through the AIDS Medi-Cal Waiver.

2. Beginning July 2014, assume the new rate will increase $1.25 per hour (or $0.3125 per 15 minute unit) from $8.00 per hour to $9.25 per hour.

   $8.00 (prior rate) + $1.00 (min. wage increase) + $0.25 (fringe benefits) = $9.25

3. Assume the average utilization per beneficiary is 841 units.

4. Assume total costs for the rate increase will be **$209,000 TF** (rounded) in FY 2014-15.

   794 beneficiaries x 841 units x $0.3125 rate per unit = $208,673 TF

5. Beginning January 1, 2016, assume the new rate will increase $1.25 per hour from $9.25 per hour to $10.50 per hour. This is a total increase of $2.50 per hour (or $0.625 per 15 minute unit) increase from the prior $8.00 rate.

   $8.00 (prior rate) + $2.00 (min. wage increase) + $0.50 (fringe benefits) = $10.50

6. Assume total costs for the rate increase will be **$325,000 TF** (rounded) in FY 2015-16.

   <u>July 2015 – December 2015:</u>
   412 beneficiaries x 841 units x $0.3125 rate per unit = $108,000 TF

   <u>January 2015 – June 2016:</u>
   412 beneficiaries x 841 units x $0.625 rate per unit = $217,000 TF

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

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER:	190
IMPLEMENTATION DATE:	1/2015
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1760

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to extension of a quality assurance fee (QAF) for hospitals from January 1, 2014 to December 31, 2016.

Authority:
SB 239 (Chapter 657, Statutes of 2013)

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans

Background:
SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

SB 239 extended the Hospital QAF program from January 1, 2014 through December 31, 2016. The Department submitted State Plan Amendments (SPA) for this program on March 31, 2014. The Department anticipates approval of these SPAs in FY 2014-15.

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

Methodology:
1. The current Hospital QAF program will end on December 31, 2016.

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 190

2. On an accrual basis, annual funds for children's health care coverage are:
   - FY 2013-14: $310,000,000
   - FY 2014-15: $740,000,000
   - FY 2015-16: $865,000,000

   SB 239 requires the Department to reconcile the funds for children's health care coverage based on the actual net benefit to the hospitals from the fee program. The FY 2014-15 and FY 2015-16 amounts are the initial children's health care coverage funds calculation and may be adjusted based on the final reconciliation.

3. On a cash basis, the payments to health care coverage for children are:

(Dollars In Thousands)

FY 2014-15	**TF**	**GF**	**Hosp. QA Rev Fund**
FY 2013-14	$0	($310,000)	$310,000
FY 2014-15	$0	($555,000)	$555,000
Total FY 2014-15	**$0**	**($865,000)**	**$865,000**

FY 2015-16	**TF**	**GF**	**Hosp. QA Rev Fund**
FY 2014-15	$0	($185,000)	$185,000
FY 2015-16	$0	($648,750)	$648,750
Total FY 2015-16	**$0**	**($833,750)**	**$833,750**

Funding:
100% GF (4260-101-0001)
100% Hospital Quality Assurance Revenue Fund (4260-611-3158)

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER:	191
IMPLEMENTATION DATE:	1/2006
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1087

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change reduces the General Fund and replaces those funds with Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts. This funding shift is identified in the management summary funding pages.

Authority:
California Tobacco Health Protection Act of 1988 (Proposition 99)
AB 75 (Chapter 1331, Statutes of 1989)

Interdependent Policy Changes:
Not Applicable

Background:
The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2014-15 and FY 2015-16. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change also estimates the CTPS/Proposition 99 funding added by the Budget Act of 2010, which provides additional funding for Medi-Cal hospital outpatient services.

Reason for Change from Prior Estimate:
There is an increase in available funds.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 191

Methodology:

FY 2014-15	
Hospital Services Account	$74,137,000
Physicians' Services Account	$105,000
Unallocated Account	$25,289,000
Total CTPS/Prop. 99	$99,531,000
GF	($99,531,000)
Net Impact	**$0**

FY 2015-16	
Hospital Services Account	$92,129,000
Physicians' Services Account	$19,446,000
Unallocated Account	$31,009,000
Total CTPS/Prop. 99	$142,584,000
GF	($142,584,000)
Net Impact	**$0**

Funding:
Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

CLPP FUND

REGULAR POLICY CHANGE NUMBER:	192
IMPLEMENTATION DATE:	7/2005
ANALYST:	Peter Bjorkman
FISCAL REFERENCE NUMBER:	1633

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change appropriates the funding for blood lead tests performed by the Medi-Cal program. It estimates the technical adjustment in funding from 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

Authority:
Health & Safety Code, Sections 105305, 105310, and 124075
Interagency Agreement (IA) #13-20109

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides blood lead tests to children who are at risk for lead poisoning, and who are:

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The state share of cost for the lead testing component is partly funded by the CLPP Fund. The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate. This policy change adjusts the CLPP funding.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products, and collected by the Board of Equalization.

Reason for Change from Prior Estimate:
No change.

CLPP FUND

REGULAR POLICY CHANGE NUMBER: 192

Methodology:

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.

2. The new IA with the Department of Public Health began October 29, 2013. The term of the IA will be from July 1, 2013 through June 30, 2016, and the CLPP funding allocated for FY 2014-15 and FY 2015-16 will be $714,000 for each year.

	CLPP Fund
Total FY 2014-15	**$714,000**
Total FY 2015-16	**$714,000**

Funding:

100% CLPP Fund (4260-111-0080)
100% GF (4260-101-0001)

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER:	193
IMPLEMENTATION DATE:	4/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1654

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the reimbursement from the California Department of Social Services (CDSS) to the Department for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:
Not applicable

Background:
In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles, partial dual eligibles and Medi-Cal only eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to manage care health plans beginning April 1, 2014.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the California Department of Social Services (CDSS) pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population. This policy change reflects the transfer of General Fund and county funds to the Department to be used to increase managed care capitation rates. An additional policy change, Transfer of IHSS Costs to CDSS, addresses the transfer of IHSS costs from managed care rates to the Department which will in turn transfer the funds to CDSS to pay the IHSS providers.

CCI-TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 193

Reason for Change from Prior Estimate:
The Department has delayed Orange to start August 2015 instead of January 2015 as previously assumed. Also, Alameda is no longer part of the CCI demonstration. Additionally, the non-dual capitated rates were updated and have a lower IHSS component within the rate.

Methodology:
1. Estimated below is the overall impact of the CCI demonstration in FY 2014-15 and FY 2015-16.

(Dollars in Thousands) **FY 2014-15**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	$5,703,559	$2,851,779	$2,851,779	$0
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($3,349,416)	($1,674,708)	($1,674,708)	$0
Defer Managed Care Payment	($764,945)	($382,473)	($382,473)	$0
Total	($4,114,361)	($2,057,181)	($2,057,181)	$0
IHSS FFS Savings (In the Base)	($723,243)	$0	($723,243)	$0
Delay 1 Checkwrite (In the Base)	$73,488	$36,744	$36,744	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	**$0**	**($723,243)**	**$0**	**$723,243**
CCI-Transfer of IHSS Costs to CDSS (PC 113)	$1,497,113	$0	$0	$1,497,113
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$50,261	$25,131	$25,131	$0
Total of CCI PCs including pass through	$2,486,817	$133,231	$133,231	$2,220,355

(Dollars in Thousands) **FY 2015-16**	**TF**	**GF**	**FFP**	**Reimbursement**
CCI-Managed Care Payments (PC 110):				
Total Managed Care Payments	$11,265,739	$5,632,869	$5,632,869	$0
CCI-Savings and Deferral (PC 136):				
Total FFS Savings	($7,948,284)	($3,974,142)	($3,974,142)	$0
Defer Managed Care Payment	($183,375)	($91,688)	($91,688)	$0
Total	($8,131,660)	($4,065,830)	($4,065,830)	$0
IHSS FFS Savings (In the Base)	($1,456,769)	$0	($1,456,769)	$0
Delay 1 Checkwrite (In the Base)	$34,490	$17,245	$17,245	$0
CCI-Transfer of IHSS Costs to DHCS (PC 193)	**$0**	**($1,456,769)**	**$0**	**$1,456,769**
CCI-Transfer of IHSS Costs to CDSS (PC 113)	$3,015,512	$0	$0	$3,015,512
CCI-Admin Costs, HCO Costs (OA 18, OA 59)	$24,222	$12,111	$12,111	$0
Total of CCI PCs including pass through	$4,751,534	$139,626	$139,626	$4,472,281

Funding:
100% Reimbursement (4260-610-0995)
General Fund (4260-101-0001)

IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER:	194
IMPLEMENTATION DATE:	8/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1746

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$213,426,000	$0
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$213,426,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$213,426,000	$0

DESCRIPTION

Purpose:
This policy change estimates the savings associated with reducing the hours of service for In-Home Supportive Services (IHSS) recipients.

Authority:
Welfare & Institutions Code 12301.06
AB 1612 (Chapter 725, Statutes of 2010)
SB 1041 (Chapter 47, Statutes of 2012)
Oster v. Lightbourne and *Dominguez v. Schwarzenegger* Settlements

Interdependent Policy Changes:
Not Applicable

Background:
Personal care services are rendered under the administrative direction of the California Department of Social Services (CDSS) for the IHSS program.

AB 1612 implemented a 3.6% across-the-board reduction in services hours for IHSS effective February 1, 2011 with a sunset date of June 30, 2012. Subsequently, through SB 1041, the 3.6% across-the-board reduction was extended for 11 months from August 2012 through June 2013. Recipients may determine which of their services will be impacted by the reduction.

In accordance with the IHSS Settlement Agreement, filed March 28, 2013, IHSS service hours were reduced by 8% (net impact 6.79%) effective July 1, 2013. This reduction was lowered to 7% (net impact 6.47%) effective July 1, 2014. The IHSS settlement resolves two class-action lawsuits: *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*.

In FY 2015-16, the 7% reduction to IHSS services hours will be restored. The restoration of service hours will be funded by the Children's Health and Human Services Special Fund which receives revenues from Managed Care plan taxes.

IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER: 194

Reason for Change from Prior Estimate:
The estimated savings have changed due to revised expenditure data provided by CDSS.

Methodology:
The estimated savings are provided by CDSS.

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

ANNUAL OPEN ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	196
IMPLEMENTATION DATE:	11/2015
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1882

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	-$5,939,000
- STATE FUNDS	$0	-$2,969,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$5,939,000
STATE FUNDS	$0	-$2,969,500
FEDERAL FUNDS	$0	-$2,969,500

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of implementing an annual open enrollment plan for Medi-Cal managed care beneficiaries, excluding seniors and persons with disabilities (SPDs), dual eligible beneficiaries receiving full scope Medicare and Medi-Cal, new adult expansion population and any other category of mandatorily enrolled beneficiaries which the director, after receiving stakeholder input, determines should not be subject to the annual open enrollment process.

Authority:
Proposed Legislation

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans
OA PC 86 HCO Annual Open Enrollment Costs

Background:
Currently, managed care enrollees may change plans on a monthly basis. This policy fosters frequent changes throughout the year which adversely affect continuity of care. The Department is proposing legislation to change the managed care enrollment policy to allow enrollees not mentioned above in Two-Plan and Geographic Managed Care counties to change plans on an annual basis. This change is consistent with the policy in most large group health plans such as CalPERS. New beneficiaries will have 90 days from their initial enrollment date to select or change their managed care plan. On an annual basis, existing members will be provided a 90-day period to change plans.

Currently, managed care plans are required to perform a health assessment each time a new beneficiary enrolls into their plan. Plans will now be required to share health records when beneficiaries switch plans.

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

ANNUAL OPEN ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 196

Methodology:

1. Assume the initial open enrollment period will be implemented November 15, 2015. From November 15, 2015, through February 15, 2016, existing plan members may elect to change their plan. Any plan changes will be effective March 1, 2016. Thereafter, plan members will have a 90-day period each year to change plans. New beneficiaries will continue to have 90 days from their initial enrollment date to select or change their managed care plan.

2. From February 16, 2016, through November 14, 2016, routine plan changes will not be allowed.

3. It is assumed that most health assessments will no longer be required when an existing beneficiary changes plans. The new plan will rely on the initial health assessment of the previous plan. The average cost of an assessment is $68.00.

4. Of the estimated 164,400 beneficiaries changing plans each year, it is assumed 85% will no longer require a health assessment and the remaining 15% will still require an additional assessment.
   - 164,400 assessments x 85% x $68.00 = $9,502,000 TF ($4,751,500 GF) annual savings
   - $9,502,000 x .625 (November 15, 2015, to June 30, 2016) = $5,939,000 ($2,969,500 GF) FY 2015-16 savings

5. Upon implementation, an initial notification will be mailed to approximately 3,200,000 beneficiaries informing them of their open enrollment period. There will be two additional mailings. Additionally, information packets will be mailed upon request to those beneficiaries who will change plans by mail. These costs are budgeted in OA PC 86 HCO Annual Open Enrollment Costs.

The savings for FY 2015-16 are expected to be:

FY 2015-16	**TF**	**GF**
Health Assessment Savings	**($5,939,000)**	**($2,970,000)**
Mailing & Related Costs	$3,930,000	$1,965,000
Total	($2,009,000)	($1,005,000)

Funding:

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

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER:	199
IMPLEMENTATION DATE:	7/2014
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1866

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,264,000	$2,332,000
- STATE FUNDS	$1,132,000	$1,166,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,264,000	$2,332,000
STATE FUNDS	$1,132,000	$1,166,000
FEDERAL FUNDS	$1,132,000	$1,166,000

DESCRIPTION

Purpose:
This policy change estimates the cost of workers' compensation coverage for Waiver Personal Care Services (WPCS) providers.

Authority:
In-Home Supportive Services v. Workers' Comp. Appeals Bd. (1984) 152 Cal.App.3d 720, 727 [199 Cal.Rptr. 697]

Interdependent Policy Changes:
Not Applicable

Background:
The WPCS benefit is designed to assist the waiver participant in gaining independence in his or her activities of daily living and preventing social isolation. These services assist the waiver participant in remaining in his or her residence and continuing to be part of the community. A waiver participant must be enrolled and receive personal care services through the federally funded State Plan Personal Care program in order to be eligible for WPCS benefits provided by a WPCS provider. There are approximately 3,500 WPCS providers that are paid via timesheets through the Case Management Information Payroll System (CMIPS II) who will be enrolled in workers' compensation. The California Department of Social Services (CDSS) will pay for the insurance claims for the WPCS providers and the Department will reimburse CDSS for the costs.

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

Methodology:
1. Assume the Department will pay workers' compensation for WPCS providers beginning July 1, 2014.

WPCS WORKERS' COMPENSATION

REGULAR POLICY CHANGE NUMBER: 199

2. Based on historical data provided by the CDSS, expenditures for FY 2014-15 are estimated to be $2,264,000 and $2,332,000 in FY 2015-16.

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

ACCELERATED ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	200
IMPLEMENTATION DATE:	10/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1884

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$715,000	$99,000
- STATE FUNDS	$357,500	$49,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$715,000	$99,000
STATE FUNDS	$357,500	$49,500
FEDERAL FUNDS	$357,500	$49,500

DESCRIPTION

Purpose:
This policy change estimates the ineligible benefit costs for children and adults that receive Medi-Cal coverage via accelerated enrollment and presumptive eligibility during the 2014-2015 Covered California open enrollment period.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Currently, children that are screened for either Medi-Cal or the Targeted Low Income Children's Program (TLICP) and are deemed eligible are provided accelerated enrollment (AE) while their application is receiving a final eligibility determination at the county level. This provides children the opportunity to receive full-scope coverage immediately while their application is under review. Additionally, there is a separate process called presumptive eligibility (PE) for deemed eligible adults which provides full-scope Medi-Cal coverage while their application is under review. Both AE and PE beneficiaries are enrolled directly into fee-for-service (FFS) Medi-Cal and are limited to 60-days of coverage.

Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and mandatory expansions. This has created an overwhelming demand at the county level to perform new eligibility determinations and process existing redeterminations. The Department has provided temporary authority for counties to grant AE and PE through the end of the 2014-2015 Covered California open enrollment period. Historically, there are a small number of beneficiaries who receive AE and PE that are determined ineligible for Medi-Cal coverage. This policy change estimates the costs associated with the ineligible population.

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

ACCELERATED ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 200

Methodology:

1) The Department estimates that 181,985 beneficiaries will receive either AE or PE during the 2014-2015 Covered California open enrollment period. Of which, it is assumed that 9,099 beneficiaries will be determined ineligible for Medi-Cal or TLICP.

2) The Department estimates the 181,985 beneficiaries will receive on average 45-days of AE or PE coverage.

3) Based on actual experience for accelerated enrollment, the Department assumes a $20.15 per member per month (PMPM) cost for children and $68.21 for adults.

4) Estimated AE costs for ineligible children are $68,000 TF ($34,000 GF) in FY 2014-15 and $5,000 TF ($2,500 GF) in FY 2015-16. Estimated PE costs for ineligible adults are $647,000 TF ($323,500 GF) in FY 2014-15 and $94,000 TF ($47,000 GF) in FY 2015-16.

5) Total estimated ineligible costs in FY 2014-15 and FY 2015-16 are:

FY 2014-15	**TF**	**GF**	**FFP**
Total	**$715,000**	**$357,500**	**$357,500**

FY 2015-16	**TF**	**GF**	**FFP**
Total	**$99,000**	**$49,500**	**$49,500**

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

ALLIED DENTAL PROFESSIONALS ENROLLMENT

REGULAR POLICY CHANGE NUMBER:	201
IMPLEMENTATION DATE:	7/2015
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1877

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$2,000,000
- STATE FUNDS	$0	$925,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$2,000,000
STATE FUNDS	$0	$925,000
FEDERAL FUNDS	$0	$1,075,000

DESCRIPTION

Purpose:
This policy change estimates the cost of enrolling Registered Dental Hygienists (RDHs), Registered Dental Hygienists in Extended Functions (RDHEFs), and Registered Dental Hygienists in Alternative Practice (RDHAPs) in the Medi-Cal Dental Services Program.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department proposes the implementation of administrative changes to allow RDHs and RDHEFs employed by a public health program, created by Federal, State, or local law or administered by a Federal, State, county, or local governmental entity to enroll as billing providers in the Medi-Cal Dental Services Program. This includes allowing RDHs and RDEFs to enroll as rendering providers if the public health program that employs them is registered as a billing provider in the Medi-Cal Dental Services Program. Reimbursement for services provided by the aforementioned allied dental professionals is limited to services provided to the extent permitted by the applicable professional licensing statutes and regulations outlined by State law and the requirements delineated in the dental Manual of Criteria. The Centers for Medicare and Medicaid Services directed the Department to update the State Plan to include these allied dental professionals as well as RDHAPs to accurately reflect the permissibility of their enrollment in the Medi-Cal Dental Services Program. As such, State Plan Amendment 14-016 is currently under development as the enrollment of these allied dental professionals is permissible under existing state law.

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

Methodology:
1. Assume the enrollment of these Allied Professionals will be effective July 1, 2015.

ALLIED DENTAL PROFESSIONALS ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 201

2. The annual cost impact based on enrollment of these professionals is estimated at $2,000,000.

FY 2015-16:	TF	GF	FF
Title XIX (50% FF / 50% GF)	$1,500,000	$750,000	$750,000
Title XIX (65% FF / 35% GF)	$500,000	$175,000	$325,000
Total	**$2,000,000**	**$925,000**	**$1,075,000**

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

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER:	202
IMPLEMENTATION DATE:	7/2015
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1885

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	-$2,293,000
- STATE FUNDS	$0	-$1,146,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$2,293,000
STATE FUNDS	$0	-$1,146,500
FEDERAL FUNDS	$0	-$1,146,500

DESCRIPTION

Purpose:
This policy change estimates savings attributed to the Pediatric Palliative Care Waiver (PPCW) Pilot Project through the FY 2015-16 caseload expansion.

Authority:
AB 1745 (Chapter 330, Statutes of 2006)

Interdependent Policy Changes:
Not applicable

Background:
AB 1745, also known as “The Nick Snow Children’s Hospice & Palliative Care Act of 2006,” required the Department to submit an application to the Centers for Medicare and Medicaid Services (CMS) for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The waiver was approved beginning April 1, 2009 through March 31, 2012. A waiver renewal was approved by CMS through March 31, 2017.

AB 1745 requires the Department to evaluate the pilot project through an independent evaluator to meet federal assurances. The University of California, Los Angeles (UCLA), Center for Health Policy Research independent evaluation found a mean reduction of $3,133 per member per month (PMPM) based on an analysis of paid and estimated unpaid claims data, this reduction was predominantly driven by a major decrease in inpatient care costs.

Based on fiscal savings and positive satisfaction ratings reflected in the independent evaluation, caseload expansion is expected to increase in FY 2015-16. Seven additional counties are expected to participate in the pilot with a commensurate increase in caseload to approximately 270 participants from 150 participants.

PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS

REGULAR POLICY CHANGE NUMBER: 202

The administrative costs of the PPCW pilot project are budgeted in other policy changes. For the FY 2015-16 expansion counties,Other Administration policy change CCS Case Management (OA 2) budgets $717,000 Total Fund (TF) for nurse liaisons and support staff. Policy change Pediatric Palliative Care Waiver (PC 45) budgets $220,000 TF for indirect services, administrative support, overhead, and training. Through the FY 2015-16 caseload expansion, a net savings of $1,356,000 TF ($857,500 GF) will be realized.

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

Methodology:
The following assumptions were used to estimate the caseload expansion cost and program savings:

1. Assume 270 members enroll in PPCW by the end of FY 2015-16.
2. Nine counties are operational in FY 2014-15 and seven additional counties will become operational, one every two months, starting July 2015 for FY 2015-16.
3. Each additional county will have 17-18 members enroll in FY 2015-16.
4. Assume a savings of $3,133 PMPM based on paid and estimated unpaid claims data, this does not include administrative costs.

FY 2015-16	TF	GF	FF
OA 2-CCS Case Management	$717,000	$179,000	$538,000
PC 45-PPCW	$220,000	$110,000	$110,000
Savings	**($2,293,000)**	**($1,146,500)**	**($1,146,500)**
Net Savings	($1,356,000)	($857,500)	($498,500)

Funding:
50% Title XIX / 50% GF (42601010001/0890)