MEDI-CAL
November 2014
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2014-15 *and* 2015-16

The Great Seal

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL
November 2014
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2014-15 and 2015-16

Fiscal Forecasting Branch
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November 2014 Medi-Cal Estimate

Current Year (FY 2014-15) Projected Expenditures Compared to the Appropriation

(Dollars in Millions)

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

Medical Care Services	FY 2014-15 Appropriation	Nov 2014 Estimate	Change	
			Amount	Percent
Total Funds	$86,107.3	$81,242.0	($4,865.3)	-5.7%
Federal Funds	$55,305.0	$53,428.7	($1,876.3)	-3.4%
General Fund	**$16,394.7**	**$16,909.7**	**$515.0**	**3.1%**
Other Non-Federal Funds	$14,407.6	$10,903.6	($3,504.0)	-24.3%

County Administration	FY 2014-15 Appropriation	Nov 2014 Estimate	Change	
			Amount	Percent
Total Funds	$3,728.2	$3,981.5	$253.3	6.8%
Federal Funds	$2,967.1	$3,207.1	$240.0	8.1%
General Fund	**$727.9**	**$747.6**	**$19.7**	**2.7%**
Other Non-Federal Funds	$33.2	$26.8	($6.4)	-19.3%

Fiscal Intermediary	FY 2014-15 Appropriation	Nov 2014 Estimate	Change	
			Amount	Percent
Total Funds	$492.9	$524.2	$31.3	6.4%
Federal Funds	$335.1	$341.6	$6.5	1.9%
General Fund	**$157.6**	**$182.5**	**$24.9**	**15.8%**
Other Non-Federal Funds	$0.2	$0.1	($0.1)	-50.0%

Total Expenditures	FY 2014-15 Appropriation	Nov 2014 Estimate	Change	
			Amount	Percent
Total Funds	$90,328.4	$85,747.8	($4,580.6)	-5.1%
Federal Funds	$58,607.3	$56,977.5	($1,629.8)	-2.8%
General Fund	**$17,280.2**	**$17,839.7**	**$559.6**	**3.2%**
Other Non-Federal Funds	$14,441.0	$10,930.5	($3,510.5)	-24.3%

Note: Totals may not add due to rounding.

November 2014 Medi-Cal Estimate

Budget Year (FY 2015-16) Projected Expenditures Compared to Current Year (FY 2014-15)

(Dollars in Millions)

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

Medical Care Services	FY 2014-15 Estimate	FY 2015-16 Estimate	Change Amount	Change Percent
Total Funds	$81,242.0	$91,331.8	$10,089.8	12.4%
Federal Funds	$53,428.7	$58,460.0	$5,031.3	9.4%
General Fund	**$16,909.7**	**$17,739.3**	**$829.6**	**4.9%**
Other Non-Federal Funds	$10,903.6	$15,132.5	$4,228.9	38.8%

County Administration	FY 2014-15 Estimate	FY 2015-16 Estimate	Change Amount	Change Percent
Total Funds	$3,981.5	$3,617.3	($364.2)	-9.1%
Federal Funds	$3,207.1	$2,869.7	($337.4)	-10.5%
General Fund	**$747.6**	**$715.6**	**($32.0)**	**-4.3%**
Other Non-Federal Funds	$26.8	$32.0	$5.2	19.4%

Fiscal Intermediary	FY 2014-15 Estimate	FY 2015-16 Estimate	Change Amount	Change Percent
Total Funds	$524.2	$463.3	($60.9)	-11.6%
Federal Funds	$341.6	$307.5	($34.1)	-10.0%
General Fund	**$182.5**	**$155.6**	**($26.9)**	**-14.7%**
Other Non-Federal Funds	$0.1	$0.2	$0.1	100.0%

Total Expenditures	FY 2014-15 Estimate	FY 2015-16 Estimate	Change Amount	Change Percent
Total Funds	$85,747.8	$95,412.4	$9,664.6	11.3%
Federal Funds	$56,977.5	$61,637.1	$4,659.7	8.2%
General Fund	**$17,839.7**	**$18,610.5**	**$770.8**	**4.3%**
Other Non-Federal Funds	$10,930.5	$15,164.7	$4,234.2	38.7%

Note: Totals may not add due to rounding.

The November 2014 Estimate for FY 2014-15 is $559.6 million General Fund greater than the FY 2014-15 Budget Appropriation.

(In Millions, May Not Add Due to Rounding)

November 2014 General Fund	$17,839.7
FY 2014-15 Appropriation	$17,280.2
General Fund Change	**$559.6**

This change from the Appropriation is explained as follows:

Medical Care Services	$515.0
County/Other Administration	$19.7
Fiscal Intermediary	$24.9

The Medi-Cal General Fund costs in FY 2015-16, as compared to FY 2014-15, are estimated in increase by $770.8 million, an increase of approximately four percent.

(In Millions, May Not Add Due to Rounding)

FY 2014-15	$17,839.7
FY 2015-16	$18,610.5
General Fund Change	**$770.8**

This change from the FY 2014-15 to FY 2015-16 is explained as follows:

Medical Care Services	$829.6
County/Other Administration	-$32.0
Fiscal Intermediary	-$26.8

The following paragraphs briefly describe the major changes in both FY 2014-15 and FY 2015-16[1]:

ACA Expansion (PCs 18, 19)

The Affordable Care Act (ACA) Optional and Mandatory Expansions decreased by $14.5 million from the appropriation in FY 2014-15 and increased by $199.2 million in FY 2015-16. Both ACA Optional and Mandatory caseload projections were updated and, compared to the appropriation, have increased significantly in FY 2014-15. For the ACA Mandatory Expansion policy change, the Department assumes a portion of the caseload is now captured in base trends.

Other ACA Items (PCs 20, 22, 24, 25, 31, 33)

The impact of a variety of other ACA items is an increase of $127.5 million from the appropriation in FY 2014-15 and an decrease of $61.3 million in FY 2015-16. These items include Express Lane Enrollment, Delay of Redeterminations, Newly Qualified Immigrants (NQI)

[1] Unless otherwise stated, the costs shown are GF dollars. FY 2014-15 dollars are the change compared to the Budget Act of 2014 appropriation. The FY 2015-16 costs are the November Estimate change from FY 20914-15 to FY 2015-16.

under ACA and the likely federal prohibition for shifting pregnant women receiving pregnancy only Medi-Cal coverage to Covered California.

Managed Care Model PCs (Base PCs 109, 111, 112, 116, and Regular PC 128)

The four major types of managed care plans increase by $337.9 million in FY 2014-15 and $456.3 million in FY 2015-16. Of the FY 2015-16 increase, $281.2 million is a placeholder for an estimated 3.57% increase in rates. Also, built into the rates are the impacts of part of the ACA mandatory expansion, Hepatitis C treatments, mental health expansion, blood factor carve-out, and AB 97 rate reductions. These adjustments are either new ones or had been previously shown in a separate policy change.

Coordinated Care Initiative (PCs 119, 123, 143, 197, OA 19, OA 89)

General Fund costs increased $97.3 million in FY 2014-15 from the appropriation and $6.4 million in FY 2015-16. The changes are a result of delaying Orange to start August 2015 rather than January and removing Alameda from the CCI demonstration. In addition to phase-in changes, rates used in the estimate have been adjusted.

MCO Tax Managed Care Plans (PC 135)

The 3.9375% MCO tax benefit to the GF is $97.7 million less in FY 2014-15 than the appropriation. The net GF benefit for the ACA expansions is now included in this PC. The decrease results from changes in CCI, ACA, and other caseloads. In FY 2015-16, the benefit to the GF increases by $330.3 million, assuming a replacement tax that results in the same level of benefit to the GF.

Behavioral Health Treatment (PC 36)

SB 870 (Chapter 40, Statutes of 2014) directs the Department to implement Behavioral Health Treatment (BHT) services to the extent it is required by the federal government. The Department has implemented BHT for EPSDT Services for children under age 21, effective July 1, 2014. The estimated GF costs are $89 million in FY 2014-15 and increasing by $62 million in FY 2015-16. The Department is working with the Department of Developmental Services (DDS) and stakeholders on a plan to transition existing Medi-Cal eligibles who are currently receiving BHT services through the Regional Centers clients. Medi-Cal costs are not included for these eligibles because the transition plan is not complete.

Dental Services (PC 120, 143, 171)

Dental rates have been updated for FY 2014-15. The restoration of select adult dental benefits and impact of implementing the change to $1,800 soft cap are incorporated into the rates. The added GF costs, excluding dental restoration, are $38 million.

General Fund Reimbursement from DPHs (PC 130)

Reimbursement from the Designated Public Hospitals (DPHs) is now expected to be $87.1 million less than the appropriation in FY 2014-15 due to a shift in collection of Year 4 payments from FY 2014-15 to FY 2015-16. FY 2015-16 payments are expected to increase by $30.9 million over FY 2014-15.

Implementation of ACA (CA 2)

The Administration has provided an additional $75 million in FY 2014-15 on a one-time basis for Medi-Cal county administration costs related to implementing required provisions of the ACA. Due to many system delays, counties are required to manually process some eligibility determinations and renewals. These manual workarounds performed by the counties require additional resources.

Enhanced Federal Funding for County Administration (CA 8)

Federal funding at 75% rather than the usual 50% is available for certain eligibility determination-related costs. The costs eligible for enhanced match include application, on-going case maintenance and renewal functions. The Estimate assumes an increase in GF savings of $122.6 million from the appropriation in FY 2014-15, based upon five quarters of added federal funding. The savings is reduced by $99.3 million in FY 2015-16, reflecting only four quarters and a reduction in ACA funding for county administrative activities.

Residential Treatment Services (PC 65)

Due to delay in waiver approval, the FY 2014-15 estimate excludes expanding Residential Treatment Services to non-perinatal beneficiaries, for a savings of $36.9 million GF. The waiver is expected to be approved in FY 2015-16 and the phased-in expansion is estimated to result in a GF increase of $19.6 million in FY 2015-16.

Mental Health Services Expansion (PC N/A)

The costs of the incorporation of non-specialty mental health services into managed care plans and the expansion of coverage to include group mental health counseling is now in the managed care model PCs and the fee-for-service base estimate. FY 2014-15 costs increased over the appropriation by $28.4 million. New caseload estimates account for the majority of this change. Costs in FY 2015-16 are $109.2 million higher due to anticipated increased utilization.

The following paragraphs briefly describe the major changes that were not discussed above under the FY 2014-15 Current Year:

AB 1629 Long Term Care Quality Assurance Fee (PCs 138, 139, 147)

On July 31, 2015, in the absence of legislation, the AB 1629 facility-specific rate methodology, Quality Assurance Fee (QAF), and Quality and Accountability Supplemental Payment Program (QASP) will sunset. The Department assumes continuation of the program beyond the July 31, 2015, sunset date. In FY 2015-16, the Estimate assumes a 3.62% total annual rate increase and the same level of GF contribution to the QASP fund as in FY 2014-15.

Designated State Health Programs (PCs 93, 103, 105)

The California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration allows the Department to claim federal financial participation using the Certified Public Expenditures (CPEs) of approved Designated State Health Programs (DSHP) and Designated Public Hospitals (DPHs) to achieve $400 million in annual GF savings.

The existing BTR Demonstration expires on October 31, 2015, and the Department intends to seek a renewal of the Waiver. However, it is not likely that the DSHP will continue after the BTR ends. The Estimate assumes an increase in GF savings of $46.2 million in FY 2014-15 from additional claims using DPH CPEs. In FY 2015-16, the Estimate assumes a decrease in GF savings of $220.55 million due to the discontinuance of the DSHP.

Health Insurer Fee (PC 205)

The ACA imposes an excise tax on certain health insurers, effective January 1, 2014. The FY 2015-16 costs is $20.3 million less than FY 2014-15 because it is based upon one year of payments rather than two.

Annual Open Enrollment (PC 196)

Under the Department's proposal, certain Medi-Cal managed care beneficiaries could change managed care plans during an annual open enrollment period. Seniors, persons with disabilities, full scope dual eligibles, COHS enrollees, and the new ACA adult expansion eligibles are excluded. This would result in a savings of $1.0 million in FY 2015-16.

General Information

This estimate is based on actual payment data through August 2014. Estimates for both fiscal years are on a cash basis.

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

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

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

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

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

Provider payment reductions, injunctions, and restorations add to this uncertainty as it disturbs the regular flow of the FI checkwrite payments. It is assumed that estimated expenditures may vary due to this uncertainty. A 1% variation in total Medi-Cal Benefits expenditures would result in a $857 million TF ($178 million General Funds) change in expenditures in FY 2014-15 and $954 million TF ($186 million General Funds) in FY 2015-16.

Medi-Cal Funding Summary

November 2014 Estimate Compared to Appropriation

Fiscal Year 2014 - 2015

TOTAL FUNDS

MEDI-CAL Benefits:	**Total Appropriation**	**Nov 2014 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001/0890(3)	$67,001,914,000	$65,637,592,000	($1,364,322,000)
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$74,137,000	$74,137,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$105,000	$105,000	$0
4260-101-0236 Prop 99 Unallocated Account	$25,289,000	$25,289,000	$0
4260-101-3168 Emergency Air Transportation Fund	$18,750,000	$26,425,000	$7,675,000
4260-101-3213 LTC QA Fund	$470,374,000	$433,863,000	($36,511,000)
4260-102-0001/0890 Capital Debt	$126,924,000	$149,342,000	$22,418,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,356,000	$2,354,000	($2,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$134,001,000	$131,371,000	($2,630,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$27,328,000	$23,348,000	($3,980,000)
4260-113-0001/0890 Healthy Families	$2,995,719,000	$2,910,176,000	($85,543,000)
4260-113-3055 County Health Initiative Match Fund	$215,000	$116,000	($99,000)
4260-601-0942142 Local Trauma Centers	$35,000,000	$51,800,000	$16,800,000
4260-601-3156 MCO Tax Fund	$1,388,941,000	$1,291,980,000	($96,961,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$576,312,000	$706,146,000	$129,834,000
4260-601-7502 Demonstration DSH Fund	$577,384,000	$624,214,000	$46,830,000
4260-601-7503 Health Care Support Fund	$801,253,000	$824,578,000	$23,325,000
4260-602-0309 Perinatal Insurance Fund	$56,396,000	$38,693,000	($17,703,000)
4260-605-0001 SNF Quality & Accountability *	$48,867,000	$48,835,000	($32,000)
4260-605-3167 SNF Quality & Accountability	$45,034,000	$45,002,000	($32,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,867,000)	($48,835,000)	$32,000
4260-606-0834 SB 1100 DSH	$617,056,000	$629,423,000	$12,367,000
4260-607-8502 Low Income Health Program IGT	$1,985,006,000	$13,290,000	($1,971,716,000)
4260-610-0995 Reimbursements	$4,641,938,000	$3,248,909,000	($1,393,029,000)
4260-610-3158 Hospital Quality Assurance Revenue	$553,000	$294,000	($259,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$97,781,000	$0	($97,781,000)
4260-611-3158 Hospital Quality Assurance Revenue	$4,406,846,000	$4,352,872,000	($53,974,000)
TOTAL MEDI-CAL Benefits	**$86,107,326,000**	**$81,242,033,000**	**($4,865,293,000)**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,583,347,000	$3,839,725,000	$256,378,000
4260-106-0890(1) Money Follow Person Fed. Grant	$517,000	$848,000	$331,000
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,660,000	$2,326,000	($334,000)
4260-113-0001/0890 Healthy Families	$102,221,000	$104,674,000	$2,453,000
4260-117-0001/0890 HIPPA	$6,267,000	$7,151,000	$884,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,000,000	($250,000)
4260-602-0313 Major Risk Medical Ins Fund	$3,750,000	$1,750,000	($2,000,000)
4260-605-3167 SNF Quality & Accountability Admin.	$2,533,000	$2,533,000	$0
4260-610-0995 Reimbursements	$13,635,000	$9,525,000	($4,110,000)
TOTAL COUNTY ADMIN.	**$3,728,180,000**	**$3,981,532,000**	**$253,352,000**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$456,441,000	$494,491,000	$38,050,000
4260-113-0001/0890 Healthy Families	$14,283,000	$5,719,000	($8,564,000)
4260-117-0001/0890 HIPAA	$22,006,000	$23,894,000	$1,888,000
4260-610-0995 Reimbursements	$141,000	$138,000	($3,000)
TOTAL FISCAL INTERMEDIARY	**$492,871,000**	**$524,242,000**	**$31,371,000**
GRAND TOTAL - ALL FUNDS	**$90,328,377,000**	**$85,747,807,000**	**($4,580,570,000)**

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

Medi-Cal Funding Summary

November 2014 Estimate Compared to Appropriation

Fiscal Year 2014 - 2015

STATE FUNDS

MEDI-CAL Benefits:	**State Funds Appropriation**	**Nov 2014 Estimate**	**Difference Incr./(Decr.)**
4260-101-0001(3) *	$15,207,011,000	$15,763,217,000	$556,206,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$74,137,000	$74,137,000	$0
4260-101-0233 Prop 99 Physician Srvc. Acct	$105,000	$105,000	$0
4260-101-0236 Prop 99 Unallocated Account	$25,289,000	$25,289,000	$0
4260-101-3168 Emergency Air Transportation Fund	$18,750,000	$26,425,000	$7,675,000
4260-101-3213 LTC QA Fund	$470,374,000	$433,863,000	($36,511,000)
4260-102-0001 Capital Debt *	$63,462,000	$74,671,000	$11,209,000
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,356,000	$2,354,000	($2,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$134,001,000	$131,371,000	($2,630,000)
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$955,017,000	$902,635,000	($52,382,000)
4260-113-3055 County Health Initiative Match Fund	$215,000	$116,000	($99,000)
4260-601-0942142 Local Trauma Centers	$35,000,000	$51,800,000	$16,800,000
4260-601-3156 MCO Tax Fund	$1,388,941,000	$1,291,980,000	($96,961,000)
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$576,312,000	$706,146,000	$129,834,000
4260-602-0309 Perinatal Insurance Fund	$56,396,000	$38,693,000	($17,703,000)
4260-605-0001 SNF Quality & Accountability *	$48,867,000	$48,835,000	($32,000)
4260-605-3167 SNF Quality & Accountability	$45,034,000	$45,002,000	($32,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,867,000)	($48,835,000)	$32,000
4260-606-0834 SB 1100 DSH	$617,056,000	$629,423,000	$12,367,000
4260-607-8502 Low Income Health Program IGT	$1,985,006,000	$13,290,000	($1,971,716,000)
4260-610-0995 Reimbursements	$4,641,938,000	$3,248,909,000	($1,393,029,000)
4260-610-3158 Hosp. Quality Assurance Revenue	$553,000	$294,000	($259,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$97,781,000	$0	($97,781,000)
4260-611-3158 Hospital Quality Assurance Revenue	$4,406,846,000	$4,352,872,000	($53,974,000)
TOTAL MEDI-CAL Benefits	**$30,802,294,000**	**$27,813,306,000**	**($2,988,988,000)**
Total Benefits General Fund *	**$16,394,657,000**	**$16,909,658,000**	**$515,001,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$695,687,000	$714,395,000	$18,708,000
4260-113-0001 Healthy Families *	$31,031,000	$31,923,000	$892,000
4260-117-0001 HIPAA *	$1,204,000	$1,286,000	$82,000
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,250,000	$13,000,000	($250,000)
4260-602-0313 Major Risk Medical Ins Fund	$3,750,000	$1,750,000	($2,000,000)
4260-605-3167 SNF Quality & Accountability Admin.	$2,533,000	$2,533,000	$0
4260-610-0995 Reimbursements	$13,635,000	$9,525,000	($4,110,000)
TOTAL COUNTY ADMIN.	**$761,090,000**	**$774,412,000**	**$13,322,000**
Total Co. Admin. General Fund *	**$727,922,000**	**$747,604,000**	**$19,682,000**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$148,964,000	$176,527,000	$27,563,000
4260-113-0001 Healthy Families *	$4,999,000	$2,001,000	($2,998,000)
4260-117-0001 HIPAA *	$3,626,000	$3,936,000	$310,000
4260-610-0995 Reimbursements	$141,000	$138,000	($3,000)
TOTAL FISCAL INTERMEDIARY	**$157,730,000**	**$182,602,000**	**$24,872,000**
Total FI General Fund *	**$157,589,000**	**$182,464,000**	**$24,875,000**
GRAND TOTAL - STATE FUNDS	**$31,721,114,000**	**$28,770,320,000**	**($2,950,794,000)**
Grand Total - General Fund *	**$17,280,168,000**	**$17,839,726,000**	**$559,558,000**

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

Medi-Cal Funding Summary

November 2014 Estimate Compared to Appropriation

Fiscal Year 2014 - 2015

FEDERAL FUNDS

	Federal Funds Appropriation	Nov 2014 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$51,794,903,000	$49,874,375,000	($1,920,528,000)
4260-102-0890 Capital Debt	$63,462,000	$74,671,000	$11,209,000
4260-106-0890 Money Follows Person Federal Grant	$27,328,000	$23,348,000	($3,980,000)
4260-113-0890 Health Families	$2,040,702,000	$2,007,541,000	($33,161,000)
4260-601-7502 Demonstration DSH Fund	$577,384,000	$624,214,000	$46,830,000
4260-601-7503 Health Care Support Fund	$801,253,000	$824,578,000	$23,325,000
TOTAL MEDI-CAL Benefits	**$55,305,032,000**	**$53,428,727,000**	**($1,876,305,000)**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$2,887,660,000	$3,125,330,000	$237,670,000
4260-106-0890(1) Money Follows Person Fed. Grant	$517,000	$848,000	$331,000
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$2,660,000	$2,326,000	($334,000)
4260-113-0890 Healthy Families	$71,190,000	$72,751,000	$1,561,000
4260-117-0890 HIPAA	$5,063,000	$5,865,000	$802,000
TOTAL COUNTY ADMIN.	**$2,967,090,000**	**$3,207,120,000**	**$240,030,000**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$307,477,000	$317,964,000	$10,487,000
4260-113-0890 Healthy Families	$9,284,000	$3,718,000	($5,566,000)
4260-117-0890 HIPAA	$18,380,000	$19,958,000	$1,578,000
TOTAL FISCAL INTERMEDIARY	**$335,141,000**	**$341,640,000**	**$6,499,000**
GRAND TOTAL - FEDERAL FUNDS	**$58,607,263,000**	**$56,977,487,000**	**($1,629,776,000)**

Medi-Cal Funding Summary
November 2014 Estimate Comparison of FY 2014-15 to FY 2015-16

TOTAL FUNDS

	FY 2014-15 Estimate	FY 2015-16 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001/0890(3)	$65,637,592,000	$71,982,752,000	$6,345,160,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$74,137,000	$92,129,000	$17,992,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$105,000	$19,446,000	$19,341,000
4260-101-0236 Prop 99 Unallocated Account	$25,289,000	$31,009,000	$5,720,000
4260-101-3168 Emergency Air Transportation Fund	$26,425,000	$5,625,000	($20,800,000)
4260-101-3213 LTC QA Fund	$433,863,000	$456,467,000	$22,604,000
4260-102-0001/0890 Capital Debt	$149,342,000	$77,340,000	($72,002,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,354,000	$1,901,000	($453,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$131,371,000	$172,402,000	$41,031,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-106-0890 Money Follows Person Federal Grant	$23,348,000	$32,316,000	$8,968,000
4260-113-0001/0890 Healthy Families	$2,910,176,000	$2,996,819,000	$86,643,000
4260-113-3055 County Health Initiative Match Fund	$116,000	$0	($116,000)
4260-601-0942142 Local Trauma Centers	$51,800,000	$40,100,000	($11,700,000)
4260-601-3156 MCO Tax Fund	$1,291,980,000	$1,790,080,000	$498,100,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$706,146,000	$701,149,000	($4,997,000)
4260-601-7502 Demonstration DSH Fund	$624,214,000	$620,142,000	($4,072,000)
4260-601-7503 Health Care Support Fund	$824,578,000	$320,700,000	($503,878,000)
4260-602-0309 Perinatal Insurance Fund	$38,693,000	$46,244,000	$7,551,000
4260-605-0001 SNF Quality & Accountability *	$48,835,000	$48,835,000	$0
4260-605-3167 SNF Quality & Accountability	$45,002,000	$45,001,000	($1,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,835,000)	($48,835,000)	$0
4260-606-0834 SB 1100 DSH	$629,423,000	$591,835,000	($37,588,000)
4260-607-8502 Low Income Health Program IGT	$13,290,000	$1,534,672,000	$1,521,382,000
4260-610-0995 Reimbursements	$3,248,909,000	$5,421,921,000	$2,173,012,000
4260-610-3158 Hospital Quality Assurance Revenue	$294,000	$0	($294,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$106,663,000	$106,663,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,352,872,000	$4,244,339,000	($108,533,000)
TOTAL MEDI-CAL Benefits	**$81,242,033,000**	**$91,331,766,000**	**$10,089,733,000**
COUNTY ADMINISTRATION:			
4260-101-0001/0890(1)	$3,839,725,000	$3,462,478,000	($377,247,000)
4260-106-0890(1) Money Follow Person Fed. Grant	$848,000	$208,000	($640,000)
4260-107-0890 Prevention of Chronic Disease (MICPD)	$2,326,000	$1,375,000	($951,000)
4260-113-0001/0890 Healthy Families	$104,674,000	$114,337,000	$9,663,000
4260-117-0001/0890 HIPPA	$7,151,000	$6,881,000	($270,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,000,000	$19,000,000	$6,000,000
4260-602-0313 Major Risk Medical Ins Fund	$1,750,000	$1,000,000	($750,000)
4260-605-3167 SNF Quality & Accountability Admin.	$2,533,000	$2,533,000	$0
4260-610-0995 Reimbursements	$9,525,000	$9,525,000	$0
TOTAL COUNTY ADMIN.	**$3,981,532,000**	**$3,617,337,000**	**($364,195,000)**
FISCAL INTERMEDIARY:			
4260-101-0001/0890(2)	$494,491,000	$446,833,000	($47,658,000)
4260-113-0001/0890 Healthy Families	$5,719,000	$5,060,000	($659,000)
4260-117-0001/0890 HIPAA	$23,894,000	$11,256,000	($12,638,000)
4260-610-0995 Reimbursements	$138,000	$136,000	($2,000)
TOTAL FISCAL INTERMEDIARY	**$524,242,000**	**$463,285,000**	**($60,957,000)**
GRAND TOTAL - ALL FUNDS	**$85,747,807,000**	**$95,412,388,000**	**$9,664,581,000**

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

Medi-Cal Funding Summary
November 2014 Estimate Comparison of FY 2014-15 to FY 2015-16

STATE FUNDS

	FY 2014-15 Estimate	FY 2015-16 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0001(3) *	$15,763,217,000	$16,619,587,000	$856,370,000
4260-101-0080 CLPP Funds	$714,000	$714,000	$0
4260-101-0232 Prop 99 Hospital Srvc. Acct.	$74,137,000	$92,129,000	$17,992,000
4260-101-0233 Prop 99 Physician Srvc. Acct	$105,000	$19,446,000	$19,341,000
4260-101-0236 Prop 99 Unallocated Account	$25,289,000	$31,009,000	$5,720,000
4260-101-3168 Emergency Air Transportation Fund	$26,425,000	$5,625,000	($20,800,000)
4260-101-3213 LTC QA Fund	$433,863,000	$456,467,000	$22,604,000
4260-102-0001 Capital Debt *	$74,671,000	$38,670,000	($36,001,000)
4260-104-0001 NDPH Hosp Supp *	$1,900,000	$1,900,000	$0
4260-601-3096 NDPH Suppl	$2,354,000	$1,901,000	($453,000)
4260-698-3096 NDPH Hosp Suppl (Less Funded by GF)	($1,900,000)	($1,900,000)	$0
4260-105-0001 Private Hosp Supp Fund *	$118,400,000	$118,400,000	$0
4260-601-3097 Private Hosp Suppl	$131,371,000	$172,402,000	$41,031,000
4260-698-3097 Private Hosp Supp (Less Funded by GF)	($118,400,000)	($118,400,000)	$0
4260-113-0001 Healthy Families *	$902,635,000	$911,862,000	$9,227,000
4260-113-3055 County Health Initiative Match Fund	$116,000	$0	($116,000)
4260-601-0942142 Local Trauma Centers	$51,800,000	$40,100,000	($11,700,000)
4260-601-3156 MCO Tax Fund	$1,291,980,000	$1,790,080,000	$498,100,000
4260-601-3172 Public Hosp. Invest., Improve. & Incentive Fund	$706,146,000	$701,149,000	($4,997,000)
4260-602-0309 Perinatal Insurance Fund	$38,693,000	$46,244,000	$7,551,000
4260-605-0001 SNF Quality & Accountability *	$48,835,000	$48,835,000	$0
4260-605-3167 SNF Quality & Accountability	$45,002,000	$45,001,000	($1,000)
4260-698-3167 SNF Qual & Acct. (Less Funded by GF)	($48,835,000)	($48,835,000)	$0
4260-606-0834 SB 1100 DSH	$629,423,000	$591,835,000	($37,588,000)
4260-607-8502 Low Income Health Program IGT	$13,290,000	$1,534,672,000	$1,521,382,000
4260-610-0995 Reimbursements	$3,248,909,000	$5,421,921,000	$2,173,012,000
4260-610-3158 Hosp. Quality Assurance Revenue	$294,000	$0	($294,000)
4260-610-3201 LIHP MCE Out-of-Network ER Svcs.	$0	$106,663,000	$106,663,000
4260-611-3158 Hospital Quality Assurance Revenue	$4,352,872,000	$4,244,339,000	($108,533,000)
TOTAL MEDI-CAL Benefits	**$27,813,306,000**	**$32,871,816,000**	**$5,058,510,000**
Total Benefits General Fund *	**$16,909,658,000**	**$17,739,254,000**	**$829,596,000**
COUNTY ADMINISTRATION:			
4260-101-0001(1) *	$714,395,000	$679,526,000	($34,869,000)
4260-113-0001 Healthy Families *	$31,923,000	$34,856,000	$2,933,000
4260-117-0001 HIPAA *	$1,286,000	$1,216,000	($70,000)
4260-601-0942285 Hlthcare Outreach & Medi-Cal Enroll. Acct.	$13,000,000	$19,000,000	$6,000,000
4260-602-0313 Major Risk Medical Ins Fund	$1,750,000	$1,000,000	($750,000)
4260-605-3167 SNF Quality & Accountability Admin.	$2,533,000	$2,533,000	$0
4260-610-0995 Reimbursements	$9,525,000	$9,525,000	$0
TOTAL COUNTY ADMIN.	**$774,412,000**	**$747,656,000**	**($26,756,000)**
Total Co. Admin. General Fund *	**$747,604,000**	**$715,598,000**	**($32,006,000)**
FISCAL INTERMEDIARY:			
4260-101-0001(2) *	$176,527,000	$151,004,000	($25,523,000)
4260-113-0001 Healthy Families *	$2,001,000	$1,771,000	($230,000)
4260-117-0001 HIPAA *	$3,936,000	$2,867,000	($1,069,000)
4260-610-0995 Reimbursements	$138,000	$136,000	($2,000)
TOTAL FISCAL INTERMEDIARY	**$182,602,000**	**$155,778,000**	**($26,824,000)**
Total FI General Fund *	**$182,464,000**	**$155,642,000**	**($26,822,000)**
GRAND TOTAL - STATE FUNDS	**$28,770,320,000**	**$33,775,250,000**	**$5,004,930,000**
Grand Total General Fund *	**$17,839,726,000**	**$18,610,494,000**	**$770,768,000**

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

Medi-Cal Funding Summary
November 2014 Estimate Comparison of FY 2014-15 to FY 2015-16

FEDERAL FUNDS

	FY 2014-15 Estimate	FY 2015-16 Estimate	Difference Incr./(Decr.)
MEDI-CAL Benefits:			
4260-101-0890(3)	$49,874,375,000	$55,363,165,000	$5,488,790,000
4260-102-0890 Capital Debt	$74,671,000	$38,670,000	($36,001,000)
4260-106-0890 Money Follows Person Federal Grant	$23,348,000	$32,316,000	$8,968,000
4260-113-0890 Health Families	$2,007,541,000	$2,084,957,000	$77,416,000
4260-601-7502 Demonstration DSH Fund	$624,214,000	$620,142,000	($4,072,000)
4260-601-7503 Health Care Support Fund	$824,578,000	$320,700,000	($503,878,000)
TOTAL MEDI-CAL Benefits	**$53,428,727,000**	**$58,459,950,000**	**$5,031,223,000**
COUNTY ADMINISTRATION:			
4260-101-0890(1)	$3,125,330,000	$2,782,952,000	($342,378,000)
4260-106-0890(1) Money Follows Person Fed. Grant	$848,000	$208,000	($640,000)
4260-107-0890 Prevention of Chronic Disease (MIPCD)	$2,326,000	$1,375,000	($951,000)
4260-113-0890 Healthy Families	$72,751,000	$79,481,000	$6,730,000
4260-117-0890 HIPAA	$5,865,000	$5,665,000	($200,000)
TOTAL COUNTY ADMIN.	**$3,207,120,000**	**$2,869,681,000**	**($337,439,000)**
FISCAL INTERMEDIARY:			
4260-101-0890(2)	$317,964,000	$295,829,000	($22,135,000)
4260-113-0890 Healthy Families	$3,718,000	$3,289,000	($429,000)
4260-117-0890 HIPAA	$19,958,000	$8,389,000	($11,569,000)
TOTAL FISCAL INTERMEDIARY	**$341,640,000**	**$307,507,000**	**($34,133,000)**
GRAND TOTAL - FEDERAL FUNDS	**$56,977,487,000**	**$61,637,138,000**	**$4,659,651,000**

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2014-15

	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
I. BASE ESTIMATES			
A. C/Y FFS BASE	$16,476,166,850	$8,238,083,420	$8,238,083,420
B. C/Y BASE POLICY CHANGES	$28,326,922,000	$17,082,247,150	$11,244,674,850
C. BASE ADJUSTMENTS	-$245,570,000	-$168,797,400	-$76,772,600
D. ADJUSTED BASE	$44,557,518,850	$25,151,533,170	$19,405,985,680
II. REGULAR POLICY CHANGES			
A. ELIGIBILITY	$795,445,020	$651,190,560	$144,254,460
B. AFFORDABLE CARE ACT	$16,189,319,040	$15,890,432,350	$298,886,690
C. BENEFITS	$688,563,380	$560,522,450	$128,040,930
D. PHARMACY	-$1,629,364,680	-$931,279,540	-$698,085,140
E. DRUG MEDI-CAL	$3,036,000	$3,036,000	$0
F. MENTAL HEALTH	$176,036,000	$165,639,000	$10,397,000
G. WAIVER--MH/UCD & BTR	$5,195,716,700	$4,184,563,850	$1,011,152,850
H. MANAGED CARE	$6,306,832,940	$2,656,358,470	$3,650,474,470
I. PROVIDER RATES	$182,152,880	$93,043,340	$89,109,540
J. SUPPLEMENTAL PMNTS.	$8,518,827,000	$4,817,690,500	$3,701,136,500
K. OTHER	$257,948,000	$185,997,000	$71,951,000
L. TOTAL CHANGES	$36,684,512,270	$28,277,193,980	$8,407,318,300
III. TOTAL MEDI-CAL ESTIMATE	**$81,242,031,120**	**$53,428,727,150**	**$27,813,303,970**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	ELIGIBILITY			
1	FAMILY PACT PROGRAM	$532,922,000	$399,345,100	$133,576,900
2	BREAST AND CERVICAL CANCER TREATMENT	$153,282,000	$85,723,300	$67,558,700
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% F	$85,180,000	$46,695,000	$38,485,000
4	MEDI-CAL ADULT INMATE PROGRAMS	$27,741,000	$27,741,000	$0
5	MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FF	$24,082,000	$15,653,300	$8,428,700
6	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM/	$22,374,000	$22,374,000	$0
7	PREGNANT WOMEN FULL SCOPE EXPANSION 60-13	$17,636,000	$8,818,000	$8,818,000
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$1,840,000	$1,196,000	$644,000
9	REFUGEES	$1,001,000	$0	$1,001,000
10	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	$740,000	$480,900	$259,100
11	NEW QUALIFIED IMMIGRANTS	$0	-$74,545,000	$74,545,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	$80,419,200	-$80,419,200
13	SCHIP FUNDING FOR PRENATAL CARE	$0	$83,328,700	-$83,328,700
15	INCARCERATION VERIFICATION PROGRAM	-$448,980	-$224,490	-$224,490
16	PARIS-VETERANS	-$1,821,000	-$910,500	-$910,500
17	TLICP PREMIUMS	-$69,083,000	-$44,903,950	-$24,179,050
	ELIGIBILITY SUBTOTAL	**$795,445,020**	**$651,190,560**	**$144,254,460**
	AFFORDABLE CARE ACT			
18	ACA OPTIONAL EXPANSION	$12,583,273,000	$12,575,955,000	$7,318,000
19	ACA MANDATORY EXPANSION	$493,984,260	$259,175,720	$234,808,540
20	ACA EXPRESS LANE ENROLLMENT	$1,309,980,000	$1,295,066,250	$14,913,750
21	PAYMENTS TO PRIMARY CARE PHYSICIANS	$932,154,590	$907,631,860	$24,522,740
22	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$499,157,000	$408,536,400	$90,620,600
23	COMMUNITY FIRST CHOICE OPTION	$248,108,000	$248,108,000	$0
24	ACA DELAY OF REDETERMINATIONS	$203,389,000	$121,851,050	$81,537,950
25	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$134,679,000	$85,852,000	$48,827,000
26	HEALTH INSURER FEE	$125,518,000	$69,035,000	$56,483,000
27	ACA EXPANSION-ADULT INMATES INPT. HOSP. COS	$51,916,000	$51,916,000	$0
28	USPSTF GRADE A AND B RECOMMENDATIONS	$2,445,190	$1,222,590	$1,222,590
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$85,513,000	-$85,513,000
30	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	-$230,000	$230,000
31	ACA MAGI SAVINGS	$0	$14,441,990	-$14,441,990
34	MANAGED CARE DRUG REBATES	-$396,000,000	-$234,000,000	-$162,000,000
200	ACCELERATED ENROLLMENT	$715,000	$357,500	$357,500
	AFFORDABLE CARE ACT SUBTOTAL	**$16,189,319,040**	**$15,890,432,360**	**$298,886,690**
	BENEFITS			
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$263,397,000	$263,397,000	$0
36	BEHAVIORAL HEALTH TREATMENT	$190,000,000	$101,000,000	$89,000,000
37	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$128,839,000	$128,839,000	$0
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$40,464,000	$20,232,000	$20,232,000

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	BENEFITS			
39	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILC	$34,020,000	$17,010,000	$17,010,000
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$21,367,000	$19,087,000	$2,280,000
41	DENTAL CHILDREN'S OUTREACH AGES 0-3	$6,590,000	$3,544,000	$3,046,000
42	VOLUNTARY INPATIENT DETOXIFICATION	$10,627,980	$6,142,100	$4,485,880
43	YOUTH REGIONAL TREATMENT CENTERS	$6,301,000	$6,271,000	$30,000
44	CCT FUND TRANSFER TO CDSS AND CDDS	$4,116,000	$4,116,000	$0
45	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$270,000
46	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$320,000	$320,000	$0
47	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$145,000	$145,000	$0
50	WOMEN'S HEALTH SERVICES	-$2,516,600	-$2,027,160	-$489,440
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$15,647,000	-$7,823,500	-$7,823,500
	BENEFITS SUBTOTAL	**$688,563,380**	**$560,522,450**	**$128,040,930**
	PHARMACY			
52	RESTORATION OF ENTERAL NUTRITION BENEFIT	$28,753,320	$14,376,660	$14,376,660
53	PEDIATRIC MOBILE VISION PROJECT	$2,036,000	$1,018,000	$1,018,000
54	NON FFP DRUGS	$0	-$1,389,000	$1,389,000
55	BCCTP DRUG REBATES	-$18,000,000	-$11,700,000	-$6,300,000
56	MEDICAL SUPPLY REBATES	-$31,000,000	-$15,500,000	-$15,500,000
57	LITIGATION SETTLEMENTS	-$40,959,000	$0	-$40,959,000
58	FAMILY PACT DRUG REBATES	-$66,036,000	-$57,752,400	-$8,283,600
59	STATE SUPPLEMENTAL DRUG REBATES	-$157,745,000	-$91,925,400	-$65,819,600
60	AGED AND DISPUTED DRUG REBATES	-$196,000,000	-$98,008,000	-$97,992,000
61	FEDERAL DRUG REBATE PROGRAM	-$1,150,414,000	-$670,399,400	-$480,014,600
	PHARMACY SUBTOTAL	**-$1,629,364,680**	**-$931,279,540**	**-$698,085,140**
	DRUG MEDI-CAL			
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$3,036,000	$0
67	ANNUAL RATE ADJUSTMENT	$0	$0	$0
	DRUG MEDI-CAL SUBTOTAL	**$3,036,000**	**$3,036,000**	**$0**
	MENTAL HEALTH			
71	ELIMINATION OF STATE MAXIMUM RATES	$91,236,000	$91,236,000	$0
72	TRANSITION OF HFP - SMH SERVICES	$42,008,000	$42,008,000	$0
73	KATIE A. V. DIANA BONTA	$27,247,000	$27,247,000	$0
75	INVESTMENT IN MENTAL HEALTH WELLNESS	$9,672,000	$9,672,000	$0
76	HEALTHY FAMILIES - SED	$4,095,000	$4,095,000	$0
77	OVER ONE-YEAR CLAIMS	$3,585,000	$3,585,000	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAY	$0	-$2,397,000	$2,397,000
80	IMD ANCILLARY SERVICES	$0	-$8,000,000	$8,000,000
81	CHART REVIEW	-$1,807,000	-$1,807,000	$0
	MENTAL HEALTH SUBTOTAL	**$176,036,000**	**$165,639,000**	**$10,397,000**

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR			
82	MH/UCD & BTR—DSH PAYMENT	$1,758,626,000	$1,191,420,000	$567,206,000
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	$1,399,432,000	$699,716,000	$699,716,000
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEM	$599,313,000	$299,656,500	$299,656,500
85	BTR - LIHP - MCE	$365,680,000	$354,297,000	$11,383,000
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	$262,741,000	$131,370,500	$131,370,500
87	BTR—SAFETY NET CARE POOL	$242,250,000	$242,250,000	$0
88	MH/UCD & BTR—CCS AND GHPP	$109,910,000	$109,910,000	$0
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SV	$92,162,000	$50,000,000	$42,162,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$87,064,000	$85,157,000	$1,907,000
91	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$84,949,000	$84,949,000	$0
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$72,800,000	$72,800,000	$0
93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$14,534,000	$346,380,000	-$331,846,000
94	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$46,822,700	$23,411,350	$23,411,350
95	MH/UCD—SAFETY NET CARE POOL	$35,917,000	$35,917,000	$0
96	BTR—INCREASE SAFETY NET CARE POOL	$30,750,000	$30,750,000	$0
97	MH/UCD—STABILIZATION FUNDING	$19,500,000	$0	$19,500,000
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INI	$13,744,000	$13,744,000	$0
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	$12,860,000	$6,430,000	$6,430,000
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$4,708,000	$2,354,000	$2,354,000
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HI	$2,756,000	$2,756,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$698,000	$698,000	$0
103	MH/UCD & BTR—BCCTP	$0	$1,980,000	-$1,980,000
104	MH/UCD & BTR—DPH INTERIM RATE	$0	$427,930,500	-$427,930,500
105	MH/UCD & BTR—MIA-LTC	$0	$21,161,000	-$21,161,000
106	BTR—INCREASE DESIGNATED STATE HEALTH PROG	$0	$30,750,000	-$30,750,000
107	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	-$19,724,000	$19,724,000
108	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOV	-$61,500,000	-$61,500,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,195,716,700**	**$4,184,563,850**	**$1,011,152,850**
	MANAGED CARE			
110	CCI-MANAGED CARE PAYMENTS	$5,191,949,760	$2,595,974,880	$2,595,974,880
113	CCI-TRANSFER OF IHSS COSTS TO CDSS	$1,497,113,000	$0	$1,497,113,000
114	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,432,849,000	$922,055,000	$510,794,000
115	MANAGED CARE RATE RANGE IGTS	$1,102,724,000	$598,230,000	$504,494,000
117	MANAGED CARE PUBLIC HOSPITAL IGTS	$384,834,000	$192,417,000	$192,417,000
118	RETRO MC RATE ADJUSTMENTS	$357,434,000	$178,717,000	$178,717,000
122	BLOOD FACTOR CARVE OUT	$37,200,000	$18,600,000	$18,600,000
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION	$23,288,000	$11,644,000	$11,644,000
124	MANAGED CARE EXPANSION TO RURAL COUNTIES	$22,744,000	$11,372,000	$11,372,000
126	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$0	$2,000,000
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	$0
130	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	MANAGED CARE			
131	EXTEND GROSS PREMIUM TAX	$0	$0	$0
132	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTME	$0	$0	$0
133	FFS COSTS FOR MANAGED CARE ENROLLEES	$0	$0	$0
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMEI	$0	$0	$0
135	MCO TAX MANAGED CARE PLANS	$0	$0	$0
136	CCI-SAVINGS AND DEFERRAL	-$3,745,302,820	-$1,872,651,410	-$1,872,651,410
	MANAGED CARE SUBTOTAL	**$6,306,832,940**	**$2,656,358,470**	**$3,650,474,470**
	PROVIDER RATES			
137	FQHC/RHC/CBRC RECONCILIATION PROCESS	$229,166,710	$114,583,360	$114,583,360
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	$90,003,000	$45,001,500	$45,001,500
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$32,440,390	$16,220,190	$16,220,190
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$42,280,000	$21,140,000	$21,140,000
141	AB 1629 ADD-ONS	$18,199,140	$9,099,570	$9,099,570
142	LTC RATE ADJUSTMENT	$23,406,700	$11,703,350	$11,703,350
143	DENTAL RETROACTIVE RATE CHANGES	$21,979,000	$12,956,400	$9,022,600
144	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$7,459,470	$3,729,740	$3,729,740
145	GENETIC DISEASE SCREENING PROGRAM FEE INCF	$5,985,600	$2,992,800	$2,992,800
146	HOSPICE RATE INCREASES	$6,052,310	$3,026,160	$3,026,160
147	LONG TERM CARE QUALITY ASSURANCE FUND EXP	$0	$0	$0
148	LABORATORY RATE METHODOLOGY CHANGE	-$14,654,480	-$7,327,240	-$7,327,240
149	NON-AB 1629 LTC RATE FREEZE	-$6,590,220	-$3,295,110	-$3,295,110
150	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$7,038,080	-$3,519,040	-$3,519,040
151	REDUCTION TO RADIOLOGY RATES	-$17,681,570	-$8,840,790	-$8,840,790
152	DRG - INPATIENT HOSPITAL PAYMENT METHODOLO	-$55,670,810	-$27,835,400	-$27,835,400
153	10% PROVIDER PAYMENT REDUCTION	-$193,184,280	-$96,592,140	-$96,592,140
	PROVIDER RATES SUBTOTAL	**$182,152,890**	**$93,043,340**	**$89,109,540**
	SUPPLEMENTAL PMNTS.			
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$6,945,877,000	$3,823,407,000	$3,122,470,000
155	HOSPITAL QAF - HOSPITAL PAYMENTS	$628,134,000	$262,438,000	$365,696,000
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$222,242,000	$222,242,000	$0
157	CAPITAL PROJECT DEBT REIMBURSEMENT	$169,187,000	$94,516,500	$74,670,500
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$165,486,000	$165,486,000	$0
159	NDPH IGT SUPPLEMENTAL PAYMENTS	$140,000,000	$70,000,000	$70,000,000
160	FFP FOR LOCAL TRAUMA CENTERS	$103,600,000	$51,800,000	$51,800,000
161	CERTIFICATION PAYMENTS FOR DP-NFS	$95,488,000	$95,488,000	$0
162	IGT PAYMENTS FOR HOSPITAL SERVICES	$15,000,000	$7,500,000	$7,500,000
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	$11,813,000	$11,813,000	$0
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSI	$10,000,000	$5,000,000	$5,000,000
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRI	$8,000,000	$4,000,000	$4,000,000
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEI	$4,000,000	$4,000,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	SUPPLEMENTAL PMNTS.			
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$8,518,827,000**	**$4,817,690,500**	**$3,701,136,500**
	OTHER			
173	ARRA HITECH - PROVIDER PAYMENTS	$217,513,000	$217,513,000	$0
175	ICF-DD TRANSPORTATION AND DAY CARE COSTS- (	$114,643,000	$114,643,000	$0
176	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	$68,216,000	$34,108,000	$34,108,000
180	AUDIT SETTLEMENTS	$33,206,000	$0	$33,206,000
181	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDD	$16,415,000	$9,934,000	$6,481,000
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$11,734,000	$8,214,000	$3,520,000
184	OVERTIME FOR IHSS PROVIDERS	$4,000,000	$2,000,000	$2,000,000
186	CDDS DENTAL SERVICES	$2,016,000	$0	$2,016,000
188	INDIAN HEALTH SERVICES	$1,158,000	$11,774,500	-$10,616,500
189	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$209,000	$104,500	$104,500
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0
191	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0
192	CLPP FUND	$0	$0	$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0
194	IHSS REDUCTION IN SERVICE HOURS	-$213,426,000	-$213,426,000	$0
199	WPCS WORKERS' COMPENSATION	$2,264,000	$1,132,000	$1,132,000
	OTHER SUBTOTAL	**$257,948,000**	**$185,997,000**	**$71,951,000**
	GRAND TOTAL	**$36,684,512,280**	**$28,277,193,980**	**$8,407,318,300**

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

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

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
PROFESSIONAL	$8,049,783,930	$5,460,435,820	$2,589,348,100
PHYSICIANS	$1,211,239,590	$822,482,370	$388,757,210
OTHER MEDICAL	$4,634,021,870	$3,363,099,330	$1,270,922,550
COUNTY OUTPATIENT	$128,822,220	$101,375,320	$27,446,910
COMMUNITY OUTPATIENT	$2,075,700,240	$1,173,478,810	$902,221,430
PHARMACY	$1,019,707,130	$573,688,120	$446,019,010
HOSPITAL INPATIENT	$13,036,479,660	$8,168,396,510	$4,868,083,140
COUNTY INPATIENT	$2,504,880,420	$1,992,935,260	$511,945,150
COMMUNITY INPATIENT	$10,531,599,240	$6,175,461,250	$4,356,137,990
LONG TERM CARE	$3,500,222,280	$1,790,839,400	$1,709,382,870
NURSING FACILITIES	$3,248,902,810	$1,663,607,060	$1,585,295,750
ICF-DD	$251,319,460	$127,232,340	$124,087,120
OTHER SERVICES	$1,005,693,900	$624,902,700	$380,791,200
MEDICAL TRANSPORTATION	$345,417,310	$287,324,670	$58,092,640
OTHER SERVICES	$466,461,400	$236,006,430	$230,454,960
HOME HEALTH	$193,815,190	$101,571,590	$92,243,600
TOTAL FEE-FOR-SERVICE	**$26,611,886,880**	**$16,618,262,550**	**$9,993,624,330**
MANAGED CARE	$39,569,324,900	$25,470,546,670	$14,098,778,230
TWO PLAN MODEL	$25,039,523,720	$15,979,977,810	$9,059,545,910
COUNTY ORGANIZED HEALTH SYSTEMS	$9,111,917,570	$6,195,118,360	$2,916,799,210
GEOGRAPHIC MANAGED CARE	$4,277,726,340	$2,699,522,660	$1,578,203,680
PHP & OTHER MANAG. CARE	$1,140,157,260	$595,927,840	$544,229,420
DENTAL	$939,168,410	$561,806,300	$377,362,110
MENTAL HEALTH	$2,197,144,920	$2,083,374,070	$113,770,850
AUDITS/ LAWSUITS	$2,168,440	$3,961,780	-$1,793,350
EPSDT SCREENS	$37,256,320	$19,394,560	$17,861,770
MEDICARE PAYMENTS	$4,135,900,000	$1,205,387,500	$2,930,512,500
STATE HOSP./DEVELOPMENTAL CNTRS.	$265,014,540	$265,009,450	$5,090
MISC. SERVICES	$7,752,934,710	$7,334,470,260	$418,464,440
RECOVERIES	-$268,768,000	-$133,486,000	-$135,282,000
GRAND TOTAL MEDI-CAL	**$81,242,031,120**	**$53,428,727,150**	**$27,813,303,970**

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

SERVICE CATEGORY	2014-15 APPROPRIATION	NOV. 2014 EST. FOR 2014-15	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$7,905,361,270	$8,049,783,930	$144,422,650	1.83
PHYSICIANS	$1,283,601,880	$1,211,239,590	-$72,362,300	-5.64
OTHER MEDICAL	$4,364,776,830	$4,634,021,870	$269,245,050	6.17
COUNTY OUTPATIENT	$147,597,560	$128,822,220	-$18,775,340	-12.72
COMMUNITY OUTPATIENT	$2,109,385,000	$2,075,700,240	-$33,684,760	-1.60
PHARMACY	$1,011,369,760	$1,019,707,130	$8,337,370	0.82
HOSPITAL INPATIENT	$13,161,701,890	$13,036,479,660	-$125,222,240	-0.95
COUNTY INPATIENT	$2,643,713,380	$2,504,880,420	-$138,832,960	-5.25
COMMUNITY INPATIENT	$10,517,988,510	$10,531,599,240	$13,610,720	0.13
LONG TERM CARE	$3,318,276,140	$3,500,222,280	$181,946,140	5.48
NURSING FACILITIES	$3,079,591,210	$3,248,902,810	$169,311,610	5.50
ICF-DD	$238,684,940	$251,319,460	$12,634,530	5.29
OTHER SERVICES	$923,431,840	$1,005,693,900	$82,262,050	8.91
MEDICAL TRANSPORTATION	$160,335,360	$345,417,310	$185,081,950	115.43
OTHER SERVICES	$560,704,580	$466,461,400	-$94,243,180	-16.81
HOME HEALTH	$202,391,910	$193,815,190	-$8,576,720	-4.24
TOTAL FEE-FOR-SERVICE	**$26,320,140,910**	**$26,611,886,880**	**$291,745,970**	**1.11**
MANAGED CARE	$40,944,108,920	$39,569,324,900	-$1,374,784,030	-3.36
TWO PLAN MODEL	$26,060,613,660	$25,039,523,720	-$1,021,089,930	-3.92
COUNTY ORGANIZED HEALTH SYSTEMS	$9,638,537,040	$9,111,917,570	-$526,619,470	-5.46
GEOGRAPHIC MANAGED CARE	$4,315,518,970	$4,277,726,340	-$37,792,630	-0.88
PHP & OTHER MANAG. CARE	$929,439,250	$1,140,157,260	$210,718,010	22.67
DENTAL	$947,437,230	$939,168,410	-$8,268,820	-0.87
MENTAL HEALTH	$2,434,957,490	$2,197,144,920	-$237,812,570	-9.77
AUDITS/ LAWSUITS	$20,358,240	$2,168,440	-$18,189,800	-89.35
EPSDT SCREENS	$37,505,900	$37,256,320	-$249,570	-0.67
MEDICARE PAYMENTS	$4,037,746,000	$4,135,900,000	$98,154,000	2.43
STATE HOSP./DEVELOPMENTAL CNTRS.	$267,389,730	$265,014,540	-$2,375,200	-0.89
MISC. SERVICES	$11,363,964,890	$7,752,934,710	-$3,611,030,190	-31.78
RECOVERIES	-$266,285,000	-$268,768,000	-$2,483,000	0.93
GRAND TOTAL MEDI-CAL	**$86,107,324,320**	**$81,242,031,120**	**-$4,865,293,190**	**-5.65**
STATE FUNDS	**$30,802,292,810**	**$27,813,303,970**	**-$2,988,988,840**	**-9.70**

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	ELIGIBILITY						
1	FAMILY PACT PROGRAM	$587,160,000	$147,064,500	$532,922,000	$133,576,900	-$54,238,000	-$13,487,600
2	BREAST AND CERVICAL CANCER TREATMENT	$159,874,000	$69,940,000	$153,282,000	$67,558,700	-$6,592,000	-$2,381,300
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPI	$126,172,000	$56,396,000	$85,180,000	$38,485,000	-$40,992,000	-$17,911,000
4	MEDI-CAL ADULT INMATE PROGRAMS	$27,477,000	$0	$27,741,000	$0	$264,000	$0
5	MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FPL	$33,232,000	$11,631,200	$24,082,000	$8,428,700	-$9,150,000	-$3,202,500
6	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	$5,469,000	$0	$22,374,000	$0	$16,905,000	$0
7	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%	$0	$0	$17,636,000	$8,818,000	$17,636,000	$8,818,000
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$1,726,000	$604,000	$1,840,000	$644,000	$114,000	$40,000
9	REFUGEES	$5,844,000	$5,844,000	$1,001,000	$1,001,000	-$4,843,000	-$4,843,000
10	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	$0	$0	$740,000	$259,100	$740,000	$259,100
11	NEW QUALIFIED IMMIGRANTS	$0	$63,324,000	$0	$74,545,000	$0	$11,221,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	-$86,018,250	$0	-$80,419,200	$0	$5,599,050
13	SCHIP FUNDING FOR PRENATAL CARE	$0	-$92,502,800	$0	-$83,328,700	$0	$9,174,100
15	INCARCERATION VERIFICATION PROGRAM	-$573,000	-$286,500	-$815,000	-$407,500	-$242,000	-$121,000
16	PARIS-VETERANS	-$4,041,760	-$2,020,880	-$4,382,670	-$2,191,340	-$340,910	-$170,450
17	TLICP PREMIUMS	$0	$0	-$69,083,000	-$24,179,050	-$69,083,000	-$24,179,050
--	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	-$8,949,550	$0	$0	$0	$8,949,550
--	PARIS-FEDERAL	-$15,826,000	-$7,913,000	$0	$0	$15,826,000	$7,913,000
--	PARIS-INTERSTATE	-$32,216,000	-$16,108,000	$0	$0	$32,216,000	$16,108,000
	ELIGIBILITY SUBTOTAL	**$894,297,240**	**$141,004,720**	**$792,517,330**	**$142,790,610**	**-$101,779,910**	**$1,785,900**
	AFFORDABLE CARE ACT						
18	ACA OPTIONAL EXPANSION	$12,553,609,000	$6,283,000	$12,583,273,000	$7,318,000	$29,664,000	$1,035,000
19	ACA MANDATORY EXPANSION	$1,673,939,000	$777,929,000	$1,603,845,000	$762,365,400	-$70,094,000	-$15,563,600
20	ACA EXPRESS LANE ENROLLMENT	$1,508,167,000	$59,423,050	$1,309,980,000	$14,913,750	-$198,187,000	-$44,509,300

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

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	AFFORDABLE CARE ACT						
21	PAYMENTS TO PRIMARY CARE PHYSICIANS	$745,128,630	$23,465,250	$977,408,610	$25,713,260	$232,279,990	$2,248,010
22	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$98,079,000	$18,945,250	$499,157,000	$90,620,600	$401,078,000	$71,675,350
23	COMMUNITY FIRST CHOICE OPTION	$228,504,000	$0	$248,108,000	$0	$19,604,000	$0
24	ACA DELAY OF REDETERMINATIONS	$53,303,000	$26,011,700	$203,389,000	$81,537,950	$150,086,000	$55,526,250
25	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$56,924,000	$20,638,000	$134,679,000	$48,827,000	$77,755,000	$28,189,000
26	HEALTH INSURER FEE	$121,306,000	$54,587,500	$125,518,000	$56,483,000	$4,212,000	$1,895,500
27	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	$67,870,000	$0	$51,916,000	$0	-$15,954,000	$0
28	USPSTF GRADE A AND B RECOMMENDATIONS	$90,749,790	$29,176,740	$9,765,120	$4,882,560	-$80,984,670	-$24,294,180
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	-$39,582,000	$0	-$85,513,000	$0	-$45,931,000
30	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	$115,000	$0	$230,000	$0	$115,000
31	ACA MAGI SAVINGS	$0	-$17,742,000	$0	-$17,742,000	$0	$0
34	MANAGED CARE DRUG REBATES	-$330,400,000	-$165,200,000	-$396,000,000	-$162,000,000	-$65,600,000	$3,200,000
200	ACCELERATED ENROLLMENT	$0	$0	$715,000	$357,500	$715,000	$357,500
--	ACA EXPANSION-PREGNANCY ONLY	-$33,145,000	-$16,572,500	$0	$0	$33,145,000	$16,572,500
--	MENTAL HEALTH SERVICES EXPANSION	$391,459,000	$138,584,950	$0	$0	-$391,459,000	-$138,584,950
--	RECOVERY AUDIT CONTRACTOR SAVINGS	-$76,610	-$38,310	$0	$0	$76,610	$38,310
	AFFORDABLE CARE ACT SUBTOTAL	**$17,225,416,810**	**$916,024,630**	**$17,351,753,740**	**$827,994,020**	**$126,336,920**	**-$88,030,610**
	BENEFITS						
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$312,967,000	$0	$263,397,000	$0	-$49,570,000	$0
36	BEHAVIORAL HEALTH TREATMENT	$0	$0	$190,000,000	$89,000,000	$190,000,000	$89,000,000
37	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$144,536,000	$0	$128,839,000	$0	-$15,697,000	$0
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$40,464,000	$20,232,000	$40,464,000	$20,232,000	$0	$0
39	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS	$34,170,000	$17,085,000	$34,020,000	$17,010,000	-$150,000	-$75,000
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$26,085,000	$2,819,000	$21,367,000	$2,280,000	-$4,718,000	-$539,000

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

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	BENEFITS						
41	DENTAL CHILDREN'S OUTREACH AGES 0-3	$17,636,000	$8,146,000	$6,590,000	$3,046,000	-$11,046,000	-$5,100,000
42	VOLUNTARY INPATIENT DETOXIFICATION	$28,925,000	$10,622,500	$25,007,000	$10,555,000	-$3,918,000	-$67,500
43	YOUTH REGIONAL TREATMENT CENTERS	$6,345,000	$34,000	$6,301,000	$30,000	-$44,000	-$4,000
44	CCT FUND TRANSFER TO CDSS AND CDDS	$3,912,000	$0	$4,116,000	$0	$204,000	$0
45	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$540,000	$270,000	$0	$0
46	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$516,000	$0	$320,000	$0	-$196,000	$0
47	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$150,000	$0	$145,000	$0	-$5,000	$0
50	WOMEN'S HEALTH SERVICES	-$20,645,660	-$4,388,190	-$8,648,090	-$1,681,930	$11,997,570	$2,706,260
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$20,218,000	-$10,109,000	-$15,647,000	-$7,823,500	$4,571,000	$2,285,500
--	COPAYMENT FOR NON-EMERGENCY ER VISITS	-$33,707,000	-$16,853,500	$0	$0	$33,707,000	$16,853,500
--	DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREI	$4,841,000	$2,420,500	$0	$0	-$4,841,000	-$2,420,500
--	RESTORATION OF SELECT ADULT DENTAL BENEFITS	$311,879,000	$109,948,000	$0	$0	-$311,879,000	-$109,948,000
	BENEFITS SUBTOTAL	**$858,395,340**	**$140,226,310**	**$696,810,910**	**$132,917,570**	**-$161,584,430**	**-$7,308,740**
	PHARMACY						
52	RESTORATION OF ENTERAL NUTRITION BENEFIT	$28,646,420	$14,323,210	$28,753,320	$14,376,660	$106,900	$53,450
53	PEDIATRIC MOBILE VISION PROJECT	$2,036,000	$1,018,000	$2,036,000	$1,018,000	$0	$0
54	NON FFP DRUGS	$0	$2,106,000	$0	$1,389,000	$0	-$717,000
55	BCCTP DRUG REBATES	-$15,764,000	-$5,517,400	-$18,000,000	-$6,300,000	-$2,236,000	-$782,600
56	MEDICAL SUPPLY REBATES	-$24,428,000	-$12,214,000	-$31,000,000	-$15,500,000	-$6,572,000	-$3,286,000
57	LITIGATION SETTLEMENTS	$0	$0	-$40,959,000	-$40,959,000	-$40,959,000	-$40,959,000
58	FAMILY PACT DRUG REBATES	-$73,085,000	-$9,357,700	-$66,036,000	-$8,283,600	$7,049,000	$1,074,100
59	STATE SUPPLEMENTAL DRUG REBATES	-$161,296,000	-$79,158,800	-$157,745,000	-$65,819,600	$3,551,000	$13,339,200
60	AGED AND DISPUTED DRUG REBATES	-$196,000,000	-$97,982,000	-$196,000,000	-$97,992,000	$0	-$10,000
61	FEDERAL DRUG REBATE PROGRAM	-$1,299,000,000	-$559,917,100	-$1,150,414,000	-$480,014,600	$148,586,000	$79,902,500

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PHARMACY						
--	STATE SUPPLEMENTAL SPECIALTY DRUG REBATES	-$12,056,000	-$6,028,000	$0	$0	$12,056,000	$6,028,000
	PHARMACY SUBTOTAL	**-$1,750,946,580**	**-$752,727,790**	**-$1,629,364,680**	**-$698,085,140**	**$121,581,900**	**$54,642,650**
	DRUG MEDI-CAL						
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$0	$3,036,000	$0	$0	$0
67	ANNUAL RATE ADJUSTMENT	-$2,607,000	-$248,000	$0	$0	$2,607,000	$248,000
	DRUG MEDI-CAL SUBTOTAL	**$429,000**	**-$248,000**	**$3,036,000**	**$0**	**$2,607,000**	**$248,000**
	MENTAL HEALTH						
71	ELIMINATION OF STATE MAXIMUM RATES	$72,161,000	$0	$91,236,000	$0	$19,075,000	$0
72	TRANSITION OF HFP - SMH SERVICES	$41,848,000	$0	$42,008,000	$0	$160,000	$0
73	KATIE A. V. DIANA BONTA	$26,751,000	$0	$27,247,000	$0	$496,000	$0
75	INVESTMENT IN MENTAL HEALTH WELLNESS	$24,800,000	$0	$9,672,000	$0	-$15,128,000	$0
76	HEALTHY FAMILIES - SED	$7,070,000	$0	$4,095,000	$0	-$2,975,000	$0
77	OVER ONE-YEAR CLAIMS	$3,000,000	$0	$3,585,000	$0	$585,000	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	$0	$0	$0	$2,397,000	$0	$2,397,000
80	IMD ANCILLARY SERVICES	$0	$6,000,000	$0	$8,000,000	$0	$2,000,000
81	CHART REVIEW	-$320,000	$0	-$1,807,000	$0	-$1,487,000	$0
--	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$0	$0	$0	$0	$0	$0
--	SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT	$0	$0	$0	$0	$0	$0
--	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	$353,018,000	$0	$0	$0	-$353,018,000	$0
	MENTAL HEALTH SUBTOTAL	**$528,328,000**	**$6,000,000**	**$176,036,000**	**$10,397,000**	**-$352,292,000**	**$4,397,000**
	WAIVER--MH/UCD & BTR						
82	MH/UCD & BTR—DSH PAYMENT	$1,762,250,000	$592,433,000	$1,758,626,000	$567,206,000	-$3,624,000	-$25,227,000
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE P(	$1,152,624,000	$576,312,000	$1,399,432,000	$699,716,000	$246,808,000	$123,404,000

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR						
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEME	$551,013,000	$275,506,500	$599,313,000	$299,656,500	$48,300,000	$24,150,000
85	BTR - LIHP - MCE	$4,210,969,000	$1,985,006,000	$365,680,000	$11,383,000	-$3,845,289,000	-$1,973,623,000
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL I	$268,001,000	$134,000,500	$262,741,000	$131,370,500	-$5,260,000	-$2,630,000
87	BTR—SAFETY NET CARE POOL	$242,250,000	$0	$242,250,000	$0	$0	$0
88	MH/UCD & BTR—CCS AND GHPP	$117,158,000	$0	$109,910,000	$0	-$7,248,000	$0
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	$275,629,000	$135,686,000	$92,162,000	$42,162,000	-$183,467,000	-$93,524,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$21,373,000	$0	$87,064,000	$1,907,000	$65,691,000	$1,907,000
91	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$435,143,000	$0	$84,949,000	$0	-$350,194,000	$0
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$85,000,000	$0	$72,800,000	$0	-$12,200,000	$0
93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$53,645,000	-$286,449,000	$14,534,000	-$331,846,000	-$39,111,000	-$45,397,000
94	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$20,369,360	$10,184,680	$47,613,070	$23,806,540	$27,243,720	$13,621,860
95	MH/UCD—SAFETY NET CARE POOL	$46,752,000	$0	$35,917,000	$0	-$10,835,000	$0
96	BTR—INCREASE SAFETY NET CARE POOL	$6,500,000	$0	$30,750,000	$0	$24,250,000	$0
97	MH/UCD—STABILIZATION FUNDING	$41,378,000	$29,628,000	$19,500,000	$19,500,000	-$21,878,000	-$10,128,000
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMA	$0	$0	$13,744,000	$0	$13,744,000	$0
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	$0	$0	$12,860,000	$6,430,000	$12,860,000	$6,430,000
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$4,712,000	$2,356,000	$4,708,000	$2,354,000	-$4,000	-$2,000
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	$2,370,000	$0	$2,756,000	$0	$386,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$0	$0	$698,000	$0	$698,000	$0
103	MH/UCD & BTR—BCCTP	$0	-$2,179,000	$0	-$1,980,000	$0	$199,000
104	MH/UCD & BTR—DPH INTERIM RATE	$0	-$392,395,000	$0	-$427,930,500	$0	-$35,535,500
105	MH/UCD & BTR—MIA-LTC	$0	-$20,118,000	$0	-$21,161,000	$0	-$1,043,000
106	BTR—INCREASE DESIGNATED STATE HEALTH PROGR	$0	-$6,500,000	$0	-$30,750,000	$0	-$24,250,000
107	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	-$8,959,000	$0	$19,724,000	$0	$28,683,000
108	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVEI	-$13,000,000	$0	-$61,500,000	$0	-$48,500,000	$0

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR						
	WAIVER--MH/UCD & BTR SUBTOTAL	**$9,284,136,360**	**$3,024,512,680**	**$5,196,507,070**	**$1,011,548,040**	**-$4,087,629,280**	**-$2,012,964,640**
	MANAGED CARE						
110	CCI-MANAGED CARE PAYMENTS	$6,901,009,000	$3,450,504,500	$5,703,559,000	$2,851,779,500	-$1,197,450,000	-$598,725,000
113	CCI-TRANSFER OF IHSS COSTS TO CDSS	$2,496,678,000	$2,496,678,000	$1,497,113,000	$1,497,113,000	-$999,565,000	-$999,565,000
114	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,481,657,000	$521,697,000	$1,432,849,000	$510,794,000	-$48,808,000	-$10,903,000
115	MANAGED CARE RATE RANGE IGTS	$860,767,000	$400,038,000	$1,102,724,000	$504,494,000	$241,957,000	$104,456,000
117	MANAGED CARE PUBLIC HOSPITAL IGTS	$431,688,000	$215,844,000	$384,834,000	$192,417,000	-$46,854,000	-$23,427,000
118	RETRO MC RATE ADJUSTMENTS	$337,849,000	$168,924,500	$357,434,000	$178,717,000	$19,585,000	$9,792,500
122	BLOOD FACTOR CARVE OUT	$0	$0	$37,200,000	$18,600,000	$37,200,000	$18,600,000
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	$0	$0	$23,288,000	$11,644,000	$23,288,000	$11,644,000
124	MANAGED CARE EXPANSION TO RURAL COUNTIES	-$26,934,000	-$13,467,000	$22,744,000	$11,372,000	$49,678,000	$24,839,000
126	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	$0	$0	$0	$0
130	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	$0	$0	$0	$0
131	EXTEND GROSS PREMIUM TAX	$0	$0	$0	$0	$0	$0
132	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMEN	$0	$0	$0	$0	$0	$0
133	FFS COSTS FOR MANAGED CARE ENROLLEES	$0	$0	$0	$0	$0	$0
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	$0	$0	$0	$0
135	MCO TAX MANAGED CARE PLANS	$0	$0	$0	$0	$0	$0
136	CCI-SAVINGS AND DEFERRAL	-$4,502,299,000	-$2,251,149,500	-$4,114,361,000	-$2,057,180,500	$387,938,000	$193,969,000
--	CAPITATED RATE ADJUSTMENT FOR FY 2014-15	$0	$0	$0	$0	$0	$0
--	DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM	-$1,071,000	-$535,500	$0	$0	$1,071,000	$535,500
--	SCAN TRANSITION TO MANAGED CARE	$0	$0	$0	$0	$0	$0
	MANAGED CARE SUBTOTAL	**$7,981,344,000**	**$4,990,534,000**	**$6,449,384,000**	**$3,721,750,000**	**-$1,531,960,000**	**-$1,268,784,000**

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NOVEMBER 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2014-15

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PROVIDER RATES						
137	FQHC/RHC/CBRC RECONCILIATION PROCESS	$194,678,560	$97,339,280	$232,349,910	$116,174,950	$37,671,350	$18,835,670
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYI	$90,068,000	$45,034,000	$90,003,000	$45,001,500	-$65,000	-$32,500
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$125,322,250	$62,661,130	$96,034,290	$48,017,150	-$29,287,960	-$14,643,980
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$30,000,000	$15,000,000	$42,280,000	$21,140,000	$12,280,000	$6,140,000
141	AB 1629 ADD-ONS	$38,764,880	$19,382,440	$18,564,870	$9,282,430	-$20,200,020	-$10,100,010
142	LTC RATE ADJUSTMENT	$23,234,380	$11,617,190	$24,014,260	$12,007,130	$779,880	$389,940
143	DENTAL RETROACTIVE RATE CHANGES	-$4,485,000	-$2,242,500	$21,979,000	$9,022,600	$26,464,000	$11,265,100
144	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$18,905,100	$9,452,550	$18,865,640	$9,432,820	-$39,470	-$19,730
145	GENETIC DISEASE SCREENING PROGRAM FEE INCRE/	$7,619,000	$3,809,500	$5,985,600	$2,992,800	-$1,633,400	-$816,700
146	HOSPICE RATE INCREASES	$11,136,200	$5,568,100	$6,180,240	$3,090,120	-$4,955,960	-$2,477,980
147	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	$0	$0	$0	$0	$0	$0
148	LABORATORY RATE METHODOLOGY CHANGE	-$10,900,700	-$5,450,350	-$14,654,480	-$7,327,240	-$3,753,780	-$1,876,890
149	NON-AB 1629 LTC RATE FREEZE	-$26,302,000	-$13,151,000	-$6,634,000	-$3,317,000	$19,668,000	$9,834,000
150	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$29,896,510	-$14,948,260	-$9,379,110	-$4,689,550	$20,517,400	$10,258,700
151	REDUCTION TO RADIOLOGY RATES	-$32,891,820	-$16,445,910	-$17,681,570	-$8,840,790	$15,210,250	$7,605,120
152	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-$185,418,780	-$92,709,390	-$171,084,230	-$85,542,110	$14,334,550	$7,167,280
153	10% PROVIDER PAYMENT REDUCTION	-$513,029,890	-$256,514,940	-$379,313,330	-$189,656,660	$133,716,560	$66,858,280
	PROVIDER RATES SUBTOTAL	**-$263,196,320**	**-$131,598,160**	**-$42,489,910**	**-$23,211,850**	**$220,706,410**	**$108,386,310**
	SUPPLEMENTAL PMNTS.						
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$6,945,877,000	$3,125,877,000	$6,945,877,000	$3,122,470,000	$0	-$3,407,000
155	HOSPITAL QAF - HOSPITAL PAYMENTS	$740,311,000	$416,522,000	$628,134,000	$365,696,000	-$112,177,000	-$50,826,000
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$20,000,000	$0	$222,242,000	$0	$202,242,000	$0
157	CAPITAL PROJECT DEBT REIMBURSEMENT	$146,731,000	$63,461,500	$169,187,000	$74,670,500	$22,456,000	$11,209,000
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$197,287,000	$0	$165,486,000	$0	-$31,801,000	$0

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

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	SUPPLEMENTAL PMNTS.						
159	NDPH IGT SUPPLEMENTAL PAYMENTS	$70,000,000	$35,000,000	$140,000,000	$70,000,000	$70,000,000	$35,000,000
160	FFP FOR LOCAL TRAUMA CENTERS	$70,000,000	$35,000,000	$103,600,000	$51,800,000	$33,600,000	$16,800,000
161	CERTIFICATION PAYMENTS FOR DP-NFS	$46,235,000	$0	$95,488,000	$0	$49,253,000	$0
162	IGT PAYMENTS FOR HOSPITAL SERVICES	$15,000,000	$7,500,000	$15,000,000	$7,500,000	$0	$0
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$183,000,000	$0	$11,813,000	$0	-$171,187,000	$0
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENT	$3,325,000	$0	$4,000,000	$0	$675,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$8,455,766,000**	**$3,692,360,500**	**$8,518,827,000**	**$3,701,136,500**	**$63,061,000**	**$8,776,000**
	OTHER						
173	ARRA HITECH - PROVIDER PAYMENTS	$149,720,000	$0	$217,513,000	$0	$67,793,000	$0
175	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CD	$107,104,000	$0	$114,643,000	$0	$7,539,000	$0
176	NONCONTRACT HOSP INPATIENT COST SETTLEMENT	$61,544,000	$30,772,000	$68,216,000	$34,108,000	$6,672,000	$3,336,000
180	AUDIT SETTLEMENTS	$9,910,000	$9,910,000	$33,206,000	$33,206,000	$23,296,000	$23,296,000
181	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$16,415,000	$6,481,000	$16,415,000	$6,481,000	$0	$0
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$3,919,000	$1,176,000	$11,734,000	$3,520,000	$7,815,000	$2,344,000
184	OVERTIME FOR IHSS PROVIDERS	$4,000,000	$2,000,000	$4,000,000	$2,000,000	$0	$0
186	CDDS DENTAL SERVICES	$11,972,000	$11,972,000	$2,016,000	$2,016,000	-$9,956,000	-$9,956,000
188	INDIAN HEALTH SERVICES	$2,180,000	-$9,435,500	$1,158,000	-$10,616,500	-$1,022,000	-$1,181,000
189	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$209,000	$104,500	$209,000	$104,500	$0	$0
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0	$0	$0	$0
191	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0	$0	$0	$0
192	CLPP FUND	$0	$0	$0	$0	$0	$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0	$0	$0	$0

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

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
194	IHSS REDUCTION IN SERVICE HOURS	-$212,833,000	$0	-$213,426,000	$0	-$593,000	$0
199	WPCS WORKERS' COMPENSATION	$0	$0	$2,264,000	$1,132,000	$2,264,000	$1,132,000
--	PACE RATE INCREASE	$3,649,000	$1,824,500	$0	$0	-$3,649,000	-$1,824,500
	OTHER SUBTOTAL	**$157,789,000**	**$54,804,500**	**$257,948,000**	**$71,951,000**	**$100,159,000**	**$17,146,500**
	GRAND TOTAL	**$43,371,758,840**	**$12,080,893,390**	**$37,770,965,450**	**$8,899,187,750**	**-$5,600,793,390**	**-$3,181,705,640**

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

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

SERVICE CATEGORY	PA-OAS	PA-AB	PA-ATD	PA-AFDC	LT-OAS	LT-AB
PHYSICIANS	$21,898,840	$2,464,800	$109,618,170	$67,548,010	$3,843,290	$67,930
OTHER MEDICAL	$50,279,590	$7,314,490	$299,541,240	$378,161,080	$6,993,370	$223,990
COUNTY OUTPATIENT	$382,770	$45,220	$4,676,320	$2,210,680	$123,540	$1,630
COMMUNITY OUTPATIENT	$6,415,430	$1,410,460	$92,205,230	$30,704,390	$551,000	$3,810
PHARMACY	$3,945,320	$2,295,030	$162,271,520	$102,478,690	$1,341,160	$22,150
COUNTY INPATIENT	$4,868,260	$492,850	$49,019,510	$32,194,850	$1,932,680	$38,630
COMMUNITY INPATIENT	$97,774,330	$11,431,590	$532,844,420	$335,625,270	$21,338,700	$303,910
NURSING FACILITIES	$378,701,440	$16,070,250	$561,473,500	$3,899,990	$1,321,969,750	$5,463,340
ICF-DD	$421,160	$5,489,730	$112,025,010	$341,520	$19,940,340	$2,107,250
MEDICAL TRANSPORTATION	$13,074,100	$2,672,680	$34,414,990	$4,096,840	$3,787,830	$79,730
OTHER SERVICES	$28,211,910	$4,747,770	$84,048,220	$38,698,490	$50,438,080	$169,620
HOME HEALTH	$444,180	$7,219,770	$99,055,000	$6,102,900	$19,430	$0
FFS SUBTOTAL	**$606,417,340**	**$61,654,640**	**$2,141,193,130**	**$1,002,062,710**	**$1,432,279,170**	**$8,481,990**
DENTAL	$41,418,190	$2,096,210	$96,797,430	$146,812,900	$4,396,070	$21,510
TWO PLAN MODEL	$868,827,940	$108,053,630	$6,410,175,190	$1,865,836,300	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$318,344,440	$26,207,240	$1,379,214,230	$448,748,530	$750,975,850	$1,671,390
GEOGRAPHIC MANAGED CARE	$158,543,640	$21,309,370	$1,219,174,760	$302,519,520	$0	$0
PHP & OTHER MANAG. CARE	$151,152,970	$3,865,840	$129,190,200	$123,704,800	$6,415,470	$0
EPSDT SCREENS	$0	$0	$0	$8,088,050	$0	$0
MEDICARE PAYMENTS	$1,420,829,920	$42,603,260	$1,339,635,730	$0	$143,244,420	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$10,789,820	$549,480	$25,426,010	$38,014,140	$1,123,940	$24,980
MISC. SERVICES	$743,962,380	$37,852,250	$3,504,844,850	$741,660	$4,650	$0
NON-FFS SUBTOTAL	**$3,713,869,310**	**$242,537,280**	**$14,104,458,400**	**$2,934,465,910**	**$906,160,390**	**$1,717,870**
TOTAL DOLLARS (1)	**$4,320,286,650**	**$304,191,920**	**$16,245,651,520**	**$3,936,528,620**	**$2,338,439,560**	**$10,199,860**
ELIGIBLES ***	**432,200**	**21,600**	**1,017,500**	**1,522,000**	**44,900**	**200**
ANNUAL $/ELIGIBLE	**$9,996**	**$14,083**	**$15,966**	**$2,586**	**$52,081**	**$50,999**
AVG. MO. $/ELIGIBLE	**$833**	**$1,174**	**$1,331**	**$216**	**$4,340**	**$4,250**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

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

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-AB	MN-ATD	MN-AFDC
PHYSICIANS	$6,290,380	$25,902,120	$21,002,080	$199,730	$34,998,950	$308,043,810
OTHER MEDICAL	$5,672,700	$141,541,100	$65,393,320	$662,700	$85,127,750	$1,035,143,820
COUNTY OUTPATIENT	$280,370	$827,030	$988,190	$20,330	$3,679,570	$22,458,240
COMMUNITY OUTPATIENT	$720,140	$29,151,430	$7,107,250	$43,360	$19,802,950	$132,809,030
PHARMACY	$2,532,630	$75,433,490	$4,589,450	$74,730	$26,097,050	$201,269,390
COUNTY INPATIENT	$16,181,570	$4,549,760	$16,227,390	$543,820	$129,536,910	$249,039,370
COMMUNITY INPATIENT	$32,723,350	$94,064,860	$67,700,900	$749,450	$254,177,400	$1,539,275,510
NURSING FACILITIES	$409,216,360	$134,260	$200,078,650	$681,720	$65,766,500	$20,344,810
ICF-DD	$101,821,150	$17,630	$533,800	$0	$6,008,740	$151,450
MEDICAL TRANSPORTATION	$1,997,640	$751,420	$12,024,930	$149,540	$15,916,830	$14,891,220
OTHER SERVICES	$10,312,870	$11,402,120	$18,908,600	$66,770	$16,725,730	$106,221,260
HOME HEALTH	$65,510	$4,250,830	$424,080	$50	$41,827,330	$10,954,500
FFS SUBTOTAL	**$587,814,680**	**$388,026,040**	**$414,978,630**	**$3,192,190**	**$699,665,720**	**$3,640,602,410**
DENTAL	$1,403,370	$13,417,520	$31,636,160	$56,990	$18,441,070	$377,124,220
TWO PLAN MODEL	$0	$874,494,430	$1,171,087,540	$3,189,670	$655,816,610	$3,716,940,410
COUNTY ORGANIZED HEALTH SYSTEMS	$265,233,220	$422,704,140	$312,942,430	$493,690	$329,656,320	$1,331,091,430
GEOGRAPHIC MANAGED CARE	$0	$185,474,110	$141,275,350	$126,090	$115,118,580	$601,940,790
PHP & OTHER MANAG. CARE	$209,800	$70,821,850	$127,063,610	$260,740	$22,640,060	$281,279,600
EPSDT SCREENS	$0	$5,093,050	$0	$0	$0	$20,059,590
MEDICARE PAYMENTS	$40,288,410	$0	$707,059,980	$0	$372,066,980	$70,171,310
STATE HOSP./DEVELOPMENTAL CNTRS.	$349,670	$0	$8,766,730	$24,980	$4,620,640	$99,905,750
MISC. SERVICES	$1,500	-$69,083,000	$574,987,970	$1,046,610	$650,369,530	$2,118,180
NON-FFS SUBTOTAL	**$307,485,960**	**$1,502,922,110**	**$3,074,819,780**	**$5,198,760**	**$2,168,729,800**	**$6,500,631,290**
TOTAL DOLLARS (1)	**$895,300,630**	**$1,890,948,150**	**$3,489,798,410**	**$8,390,950**	**$2,868,395,520**	**$10,141,233,700**
ELIGIBLES ***	**14,200**	**952,200**	**358,200**	**600**	**189,200**	**3,998,200**
ANNUAL $/ELIGIBLE	**$63,049**	**$1,986**	**$9,743**	**$13,985**	**$15,161**	**$2,536**
AVG. MO. $/ELIGIBLE	**$5,254**	**$165**	**$812**	**$1,165**	**$1,263**	**$211**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

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

SERVICE CATEGORY	MI-C	MI-A	REFUGEE	OBRA	POV 185	POV 133
PHYSICIANS	$42,884,090	$64,919,300	$303,090	$50,776,940	$244,106,860	$5,448,210
OTHER MEDICAL	$124,987,220	$1,575,847,670	$1,493,180	$54,253,360	$292,552,310	$51,775,450
COUNTY OUTPATIENT	$1,980,530	$3,844,370	$33,900	$10,168,840	$4,171,160	$242,140
COMMUNITY OUTPATIENT	$16,328,680	$14,449,170	$114,410	$14,749,510	$33,955,070	$4,422,660
PHARMACY	$52,265,310	$209,027,880	$544,990	$20,421,710	$13,083,560	$5,799,360
COUNTY INPATIENT	$18,453,960	$63,202,150	$24,540	$111,474,340	$90,869,450	$687,840
COMMUNITY INPATIENT	$115,618,810	$232,518,460	$593,770	$222,770,260	$690,341,480	$24,588,490
NURSING FACILITIES	$5,421,200	$29,073,460	$36,780	$19,576,340	$412,580	$731,260
ICF-DD	$1,467,350	$701,970	$0	$250,670	$0	$0
MEDICAL TRANSPORTATION	$1,964,410	$6,217,570	$10,300	$5,510,790	$2,211,450	$264,980
OTHER SERVICES	$12,817,150	$32,291,790	$16,850	$4,290,160	$16,897,950	$5,012,780
HOME HEALTH	$14,384,630	$88,840	$1,320	$17,060	$1,674,330	$1,067,050
FFS SUBTOTAL	**$408,573,350**	**$2,232,182,610**	**$3,173,130**	**$514,259,970**	**$1,390,276,190**	**$100,040,220**
DENTAL	$29,238,370	$131,741,060	$244,450	$211,630	$1,153,600	$17,615,820
TWO PLAN MODEL	$63,255,800	$6,321,198,580	$1,190,430	$0	$129,615,060	$208,787,430
COUNTY ORGANIZED HEALTH SYSTEMS	$48,313,900	$2,710,178,680	$259,060	$6,621,490	$51,734,990	$98,453,830
GEOGRAPHIC MANAGED CARE	$9,822,650	$1,003,012,820	$510,000	$0	$21,483,960	$50,441,310
PHP & OTHER MANAG. CARE	$6,949,750	$24,858,090	$13,580	$0	$10,025,320	$14,473,760
EPSDT SCREENS	$1,172,150	$0	$0	$0	$0	$1,118,500
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$6,044,300	$54,273,800	$0	$74,930	$6,643,730	$0
MISC. SERVICES	$22,540,170	$317,001,140	$0	$0	$76,310	$58,420
NON-FFS SUBTOTAL	**$187,337,100**	**$10,562,264,170**	**$2,217,520**	**$6,908,050**	**$220,732,990**	**$390,949,070**
TOTAL DOLLARS (1)	**$595,910,450**	**$12,794,446,790**	**$5,390,650**	**$521,168,020**	**$1,611,009,180**	**$490,989,290**
ELIGIBLES ***	**241,500**	**2,172,700**	**2,500**	**184,100**	**266,000**	**220,300**
ANNUAL $/ELIGIBLE	**$2,468**	**$5,889**	**$2,156**	**$2,831**	**$6,056**	**$2,229**
AVG. MO. $/ELIGIBLE	**$206**	**$491**	**$180**	**$236**	**$505**	**$186**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

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

SERVICE CATEGORY	POV 100	TOTAL
PHYSICIANS	$9,761,260	**$1,020,077,850**
OTHER MEDICAL	$58,379,500	**$4,235,343,840**
COUNTY OUTPATIENT	$549,130	**$56,683,940**
COMMUNITY OUTPATIENT	$7,810,910	**$412,754,910**
PHARMACY	$11,405,050	**$894,898,460**
COUNTY INPATIENT	$3,728,300	**$793,066,200**
COMMUNITY INPATIENT	$46,379,380	**$4,320,820,340**
NURSING FACILITIES	$513,630	**$3,039,565,810**
ICF-DD	$41,700	**$251,319,460**
MEDICAL TRANSPORTATION	$490,440	**$120,527,670**
OTHER SERVICES	$9,804,560	**$451,082,670**
HOME HEALTH	$1,769,750	**$189,366,570**
FFS SUBTOTAL	**$150,633,620**	**$15,785,507,730**
DENTAL	$22,319,020	**$936,145,600**
TWO PLAN MODEL	$304,502,080	**$22,702,971,130**
COUNTY ORGANIZED HEALTH SYSTEMS	$130,413,550	**$8,633,258,410**
GEOGRAPHIC MANAGED CARE	$73,216,680	**$3,903,969,660**
PHP & OTHER MANAG. CARE	$22,013,270	**$994,938,720**
EPSDT SCREENS	$1,723,120	**$37,254,460**
MEDICARE PAYMENTS	$0	**$4,135,900,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	$8,367,110	**$265,000,000**
MISC. SERVICES	$73,910	**$5,786,596,510**
NON-FFS SUBTOTAL	**$562,628,740**	**$47,396,034,490**
TOTAL DOLLARS (1)	**$713,262,360**	**$63,181,542,230**
ELIGIBLES ***	**334,600**	**11,972,700**
ANNUAL $/ELIGIBLE	**$2,132**	**$5,277**
AVG. MO. $/ELIGIBLE	**$178**	**$440**

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

Excluded policy changes: 70. Refer to page following report for listing.

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

EXCLUDED POLICY CHANGES: 70

1	FAMILY PACT PROGRAM
2	BREAST AND CERVICAL CANCER TREATMENT
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPL
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	SCHIP FUNDING FOR PRENATAL CARE
14	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
31	ACA MAGI SAVINGS
50	WOMEN'S HEALTH SERVICES
54	NON FFP DRUGS
58	FAMILY PACT DRUG REBATES
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
78	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
82	MH/UCD & BTR—DSH PAYMENT
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
85	BTR - LIHP - MCE
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYME
87	BTR—SAFETY NET CARE POOL
88	MH/UCD & BTR—CCS AND GHPP
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
93	BTR—DESIGNATED STATE HEALTH PROGRAMS
95	MH/UCD—SAFETY NET CARE POOL
96	BTR—INCREASE SAFETY NET CARE POOL
97	MH/UCD—STABILIZATION FUNDING
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PI

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

EXCLUDED POLICY CHANGES: 70

102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
103	MH/UCD & BTR—BCCTP
104	MH/UCD & BTR—DPH INTERIM RATE
105	MH/UCD & BTR—MIA-LTC
106	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
107	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
108	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNI
113	CCI-TRANSFER OF IHSS COSTS TO CDSS
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE
130	GENERAL FUND REIMBURSEMENTS FROM DPHS
131	EXTEND GROSS PREMIUM TAX
132	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
143	DENTAL RETROACTIVE RATE CHANGES
147	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITUF
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
155	HOSPITAL QAF - HOSPITAL PAYMENTS
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM
157	CAPITAL PROJECT DEBT REIMBURSEMENT
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
159	NDPH IGT SUPPLEMENTAL PAYMENTS
160	FFP FOR LOCAL TRAUMA CENTERS
161	CERTIFICATION PAYMENTS FOR DP-NFS
162	IGT PAYMENTS FOR HOSPITAL SERVICES
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
173	ARRA HITECH - PROVIDER PAYMENTS
177	MEDI-CAL TCM PROGRAM
180	AUDIT SETTLEMENTS

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

EXCLUDED POLICY CHANGES: 70

186	CDDS DENTAL SERVICES
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
191	CIGARETTE AND TOBACCO SURTAX FUNDS
192	CLPP FUND
193	CCI-TRANSFER OF IHSS COSTS TO DHCS
200	ACCELERATED ENROLLMENT

MEDI-CAL PROGRAM ESTIMATE SUMMARY
FISCAL YEAR 2015-16

	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
I. BASE ESTIMATES			
A. B/Y FFS BASE	$17,197,916,280	$8,598,958,140	$8,598,958,140
B. B/Y BASE POLICY CHANGES	$29,465,928,000	$17,835,444,650	$11,630,483,350
C. BASE ADJUSTMENTS	-$242,128,000	-$179,377,800	-$62,750,200
D. ADJUSTED BASE	$46,421,716,280	$26,255,024,990	$20,166,691,290
II. REGULAR POLICY CHANGES			
A. ELIGIBILITY	$879,286,480	$762,244,590	$117,041,890
B. AFFORDABLE CARE ACT	$17,028,998,310	$16,683,713,570	$345,284,740
C. BENEFITS	$883,227,970	$679,852,410	$203,375,560
D. PHARMACY	-$1,691,471,000	-$993,954,700	-$697,516,300
E. DRUG MEDI-CAL	$8,434,000	$7,641,000	$793,000
F. MENTAL HEALTH	$629,453,000	$602,623,000	$26,830,000
G. WAIVER--MH/UCD & BTR	$8,368,439,680	$5,547,186,340	$2,821,253,340
H. MANAGED CARE	$9,914,259,010	$3,743,597,700	$6,170,661,310
I. PROVIDER RATES	$283,684,230	$141,842,120	$141,842,120
J. SUPPLEMENTAL PMNTS.	$8,274,372,000	$4,733,513,000	$3,540,859,000
K. OTHER	$331,365,000	$296,666,000	$34,699,000
L. TOTAL CHANGE	$44,910,048,690	$32,204,925,040	$12,705,123,650
III. TOTAL MEDI-CAL ESTIMATE	**$91,331,764,970**	**$58,459,950,030**	**$32,871,814,940**

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	ELIGIBILITY			
1	FAMILY PACT PROGRAM	$571,452,000	$428,217,800	$143,234,200
2	BREAST AND CERVICAL CANCER TREATMENT	$162,970,000	$91,474,500	$71,495,500
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% F	$99,663,000	$55,032,000	$44,631,000
4	MEDI-CAL ADULT INMATE PROGRAMS	$49,009,000	$49,009,000	$0
5	MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FF	$25,751,000	$16,738,150	$9,012,850
6	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INM/	$31,546,000	$31,546,000	$0
7	PREGNANT WOMEN FULL SCOPE EXPANSION 60-13	$2,699,000	$1,349,500	$1,349,500
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$1,661,000	$1,080,000	$581,000
9	REFUGEES	$1,012,000	$0	$1,012,000
10	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	$5,747,000	$3,736,050	$2,010,950
11	NEW QUALIFIED IMMIGRANTS	$0	-$74,545,000	$74,545,000
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	$80,419,200	-$80,419,200
13	SCHIP FUNDING FOR PRENATAL CARE	$0	$85,415,200	-$85,415,200
14	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$39,460,000	-$39,460,000
15	INCARCERATION VERIFICATION PROGRAM	-$914,340	-$457,170	-$457,170
16	PARIS-VETERANS	-$802,180	-$401,090	-$401,090
17	TLICP PREMIUMS	-$70,507,000	-$45,829,550	-$24,677,450
	ELIGIBILITY SUBTOTAL	**$879,286,480**	**$762,244,590**	**$117,041,890**
	AFFORDABLE CARE ACT			
18	ACA OPTIONAL EXPANSION	$14,319,656,000	$14,312,171,000	$7,485,000
19	ACA MANDATORY EXPANSION	$715,246,030	$374,914,550	$340,331,480
20	ACA EXPRESS LANE ENROLLMENT	$1,222,964,000	$1,207,718,250	$15,245,750
22	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$689,780,000	$564,552,250	$125,227,750
23	COMMUNITY FIRST CHOICE OPTION	$225,260,000	$225,260,000	$0
24	ACA DELAY OF REDETERMINATIONS	$43,470,000	$25,633,700	$17,836,300
25	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$95,588,000	$60,933,000	$34,655,000
26	HEALTH INSURER FEE	$80,353,000	$44,194,000	$36,159,000
27	ACA EXPANSION-ADULT INMATES INPT. HOSP. COS	$51,916,000	$51,916,000	$0
28	USPSTF GRADE A AND B RECOMMENDATIONS	$469,180	$234,590	$234,590
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	$45,544,000	-$45,544,000
31	ACA MAGI SAVINGS	$0	$16,294,180	-$16,294,180
32	RECOVERY AUDIT CONTRACTOR SAVINGS	-$2,890	-$1,440	-$1,440
34	MANAGED CARE DRUG REBATES	-$415,800,000	-$245,700,000	-$170,100,000
200	ACCELERATED ENROLLMENT	$99,000	$49,500	$49,500
	AFFORDABLE CARE ACT SUBTOTAL	**$17,028,998,320**	**$16,683,713,570**	**$345,284,740**
	BENEFITS			
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$291,544,000	$291,544,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	BENEFITS			
36	BEHAVIORAL HEALTH TREATMENT	$320,000,000	$169,000,000	$151,000,000
37	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$130,839,000	$130,839,000	$0
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$40,464,000	$20,232,000	$20,232,000
39	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILC	$34,020,000	$17,010,000	$17,010,000
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$31,677,000	$27,831,000	$3,846,000
41	DENTAL CHILDREN'S OUTREACH AGES 0-3	$22,251,000	$11,977,000	$10,274,000
42	VOLUNTARY INPATIENT DETOXIFICATION	$9,685,790	$5,563,460	$4,122,330
43	YOUTH REGIONAL TREATMENT CENTERS	$6,589,000	$6,553,000	$36,000
44	CCT FUND TRANSFER TO CDSS AND CDDS	$4,330,000	$4,330,000	$0
45	PEDIATRIC PALLIATIVE CARE WAIVER	$760,000	$380,000	$380,000
46	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$411,000	$411,000	$0
47	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$155,000	$155,000	$0
48	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FO	$18,236,000	$9,801,700	$8,434,300
49	CHDP PROGRAM DENTAL REFERRAL	$808,000	$404,000	$404,000
50	WOMEN'S HEALTH SERVICES	-$6,767,820	-$5,366,750	-$1,401,070
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$21,481,000	-$10,740,500	-$10,740,500
201	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$2,000,000	$1,075,000	$925,000
202	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVI	-$2,293,000	-$1,146,500	-$1,146,500
	BENEFITS SUBTOTAL	**$883,227,970**	**$679,852,410**	**$203,375,560**
	PHARMACY			
52	RESTORATION OF ENTERAL NUTRITION BENEFIT	$28,892,000	$14,446,000	$14,446,000
53	PEDIATRIC MOBILE VISION PROJECT	$4,072,000	$2,036,000	$2,036,000
54	NON FFP DRUGS	$0	-$1,550,000	$1,550,000
55	BCCTP DRUG REBATES	-$18,000,000	-$11,700,000	-$6,300,000
56	MEDICAL SUPPLY REBATES	-$31,000,000	-$15,500,000	-$15,500,000
58	FAMILY PACT DRUG REBATES	-$66,036,000	-$57,752,400	-$8,283,600
59	STATE SUPPLEMENTAL DRUG REBATES	-$173,570,000	-$101,162,200	-$72,407,800
60	AGED AND DISPUTED DRUG REBATES	-$170,000,000	-$85,006,800	-$84,993,200
61	FEDERAL DRUG REBATE PROGRAM	-$1,265,829,000	-$737,765,300	-$528,063,700
	PHARMACY SUBTOTAL	**-$1,691,471,000**	**-$993,954,700**	**-$697,516,300**
	DRUG MEDI-CAL			
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$3,036,000	$0
67	ANNUAL RATE ADJUSTMENT	$5,398,000	$4,605,000	$793,000
	DRUG MEDI-CAL SUBTOTAL	**$8,434,000**	**$7,641,000**	**$793,000**
	MENTAL HEALTH			
71	ELIMINATION OF STATE MAXIMUM RATES	$93,734,000	$93,734,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	MENTAL HEALTH			
72	TRANSITION OF HFP - SMH SERVICES	$42,520,000	$42,520,000	$0
73	KATIE A. V. DIANA BONTA	$36,192,000	$36,192,000	$0
74	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$27,375,000	$3,545,000	$23,830,000
75	INVESTMENT IN MENTAL HEALTH WELLNESS	$12,276,000	$12,276,000	$0
76	HEALTHY FAMILIES - SED	$186,000	$186,000	$0
77	OVER ONE-YEAR CLAIMS	$942,000	$942,000	$0
78	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURS	$417,023,000	$417,023,000	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAY	$0	$0	$0
80	IMD ANCILLARY SERVICES	$0	-$3,000,000	$3,000,000
81	CHART REVIEW	-$795,000	-$795,000	$0
	MENTAL HEALTH SUBTOTAL	**$629,453,000**	**$602,623,000**	**$26,830,000**
	WAIVER--MH/UCD & BTR			
82	MH/UCD & BTR—DSH PAYMENT	$1,753,168,000	$1,186,655,000	$566,513,000
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE	$1,402,298,000	$701,149,000	$701,149,000
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEM	$545,435,000	$272,717,500	$272,717,500
85	BTR - LIHP - MCE	$3,412,258,000	$1,877,586,000	$1,534,672,000
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTA	$344,803,000	$172,401,500	$172,401,500
87	BTR—SAFETY NET CARE POOL	$122,917,000	$122,917,000	$0
88	MH/UCD & BTR—CCS AND GHPP	$6,882,000	$6,882,000	$0
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SV	$213,326,000	$106,663,000	$106,663,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$21,750,000	$21,750,000	$0
91	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$326,815,000	$326,815,000	$0
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$80,000,000	$80,000,000	$0
93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$18,191,000	$146,809,000	-$128,618,000
94	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$100,260,690	$50,130,340	$50,130,340
95	MH/UCD—SAFETY NET CARE POOL	$10,835,000	$10,835,000	$0
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$3,801,000	$1,900,500	$1,900,500
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HE	$2,161,000	$2,161,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$3,539,000	$3,539,000	$0
103	MH/UCD & BTR—BCCTP	$0	$655,000	-$655,000
104	MH/UCD & BTR—DPH INTERIM RATE	$0	$450,468,500	-$450,468,500
105	MH/UCD & BTR—MIA-LTC	$0	$5,152,000	-$5,152,000
	WAIVER--MH/UCD & BTR SUBTOTAL	**$8,368,439,690**	**$5,547,186,340**	**$2,821,253,340**
	MANAGED CARE			
110	CCI-MANAGED CARE PAYMENTS	$10,868,058,410	$5,434,029,210	$5,434,029,210
113	CCI-TRANSFER OF IHSS COSTS TO CDSS	$3,015,512,000	$0	$3,015,512,000
114	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,909,157,000	$1,203,448,500	$705,708,500

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	MANAGED CARE			
115	MANAGED CARE RATE RANGE IGTS	$864,408,000	$468,943,000	$395,465,000
117	MANAGED CARE PUBLIC HOSPITAL IGTS	$478,650,000	$239,325,000	$239,325,000
122	BLOOD FACTOR CARVE OUT	$43,900,000	$21,950,000	$21,950,000
124	MANAGED CARE EXPANSION TO RURAL COUNTIES	$1,472,000	$736,000	$736,000
126	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$0	$2,000,000
128	CAPITATED RATE ADJUSTMENT FOR FY 2015-16	$581,653,000	$300,441,700	$281,211,300
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	$0
130	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	$0
133	FFS COSTS FOR MANAGED CARE ENROLLEES	$0	$0	$0
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMEI	$0	$0	$0
135	MCO TAX MANAGED CARE PLANS	$0	$0	$0
136	CCI-SAVINGS AND DEFERRAL	-$7,844,612,400	-$3,922,306,200	-$3,922,306,200
196	ANNUAL OPEN ENROLLMENT	-$5,939,000	-$2,969,500	-$2,969,500
	MANAGED CARE SUBTOTAL	**$9,914,259,010**	**$3,743,597,710**	**$6,170,661,310**
	PROVIDER RATES			
137	FQHC/RHC/CBRC RECONCILIATION PROCESS	$256,904,890	$128,452,440	$128,452,440
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PA	$90,002,000	$45,001,000	$45,001,000
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$175,273,650	$87,636,820	$87,636,820
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$9,000,000	$4,500,000	$4,500,000
141	AB 1629 ADD-ONS	$84,542,570	$42,271,290	$42,271,290
142	LTC RATE ADJUSTMENT	$67,063,270	$33,531,640	$33,531,640
144	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$18,772,880	$9,386,440	$9,386,440
145	GENETIC DISEASE SCREENING PROGRAM FEE INCF	$7,407,180	$3,703,590	$3,703,590
146	HOSPICE RATE INCREASES	$12,880,270	$6,440,140	$6,440,140
147	LONG TERM CARE QUALITY ASSURANCE FUND EXP	$0	$0	$0
148	LABORATORY RATE METHODOLOGY CHANGE	-$55,494,030	-$27,747,020	-$27,747,020
149	NON-AB 1629 LTC RATE FREEZE	-$26,267,230	-$13,133,620	-$13,133,620
150	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$18,672,040	-$9,336,020	-$9,336,020
151	REDUCTION TO RADIOLOGY RATES	-$42,212,150	-$21,106,080	-$21,106,080
152	DRG - INPATIENT HOSPITAL PAYMENT METHODOLO	-$79,692,410	-$39,846,210	-$39,846,210
153	10% PROVIDER PAYMENT REDUCTION	-$215,824,610	-$107,912,310	-$107,912,300
	PROVIDER RATES SUBTOTAL	**$283,684,240**	**$141,842,120**	**$141,842,120**
	SUPPLEMENTAL PMNTS.			
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$7,547,970,000	$4,137,381,000	$3,410,589,000
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$61,759,000	$61,759,000	$0
157	CAPITAL PROJECT DEBT REIMBURSEMENT	$97,148,000	$58,478,000	$38,670,000
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$173,833,000	$173,833,000	$0

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

SUMMARY OF REGULAR POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	SUPPLEMENTAL PMNTS.			
159	NDPH IGT SUPPLEMENTAL PAYMENTS	$70,000,000	$35,000,000	$35,000,000
160	FFP FOR LOCAL TRAUMA CENTERS	$80,200,000	$40,100,000	$40,100,000
161	CERTIFICATION PAYMENTS FOR DP-NFS	$46,924,000	$46,924,000	$0
162	IGT PAYMENTS FOR HOSPITAL SERVICES	$15,000,000	$7,500,000	$7,500,000
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENT	$159,938,000	$159,938,000	$0
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSI	$10,000,000	$5,000,000	$5,000,000
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRI	$8,000,000	$4,000,000	$4,000,000
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMEN	$3,600,000	$3,600,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$8,274,372,000**	**$4,733,513,000**	**$3,540,859,000**
	OTHER			
173	ARRA HITECH - PROVIDER PAYMENTS	$114,822,000	$114,822,000	$0
175	ICF-DD TRANSPORTATION AND DAY CARE COSTS- (	$122,158,000	$122,158,000	$0
176	NONCONTRACT HOSP INPATIENT COST SETTLEMEN	$66,980,000	$33,490,000	$33,490,000
180	AUDIT SETTLEMENTS	$0	$0	$0
181	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDD	$16,415,000	$9,934,000	$6,481,000
184	OVERTIME FOR IHSS PROVIDERS	$4,000,000	$2,000,000	$2,000,000
186	CDDS DENTAL SERVICES	$2,016,000	$0	$2,016,000
188	INDIAN HEALTH SERVICES	$2,317,000	$12,933,500	-$10,616,500
189	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$325,000	$162,500	$162,500
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0
191	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0
192	CLPP FUND	$0	$0	$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0
199	WPCS WORKERS' COMPENSATION	$2,332,000	$1,166,000	$1,166,000
	OTHER SUBTOTAL	**$331,365,000**	**$296,666,000**	**$34,699,000**
	GRAND TOTAL	**$44,910,048,700**	**$32,204,925,050**	**$12,705,123,660**

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

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
FISCAL YEAR 2015-16

SERVICE CATEGORY	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
PROFESSIONAL	$7,169,876,880	$4,924,314,930	$2,245,561,950
PHYSICIANS	$871,021,240	$555,787,910	$315,233,340
OTHER MEDICAL	$4,482,982,060	$3,301,539,800	$1,181,442,260
COUNTY OUTPATIENT	$124,623,920	$100,056,480	$24,567,430
COMMUNITY OUTPATIENT	$1,691,249,660	$966,930,740	$724,318,920
PHARMACY	$123,173,730	$72,603,900	$50,569,840
HOSPITAL INPATIENT	$11,313,101,110	$7,243,169,470	$4,069,931,640
COUNTY INPATIENT	$2,379,778,180	$1,919,433,410	$460,344,770
COMMUNITY INPATIENT	$8,933,322,940	$5,323,736,060	$3,609,586,880
LONG TERM CARE	$1,698,499,100	$868,127,370	$830,371,730
NURSING FACILITIES	$1,591,912,500	$812,456,000	$779,456,500
ICF-DD	$106,586,600	$55,671,370	$50,915,230
OTHER SERVICES	$638,117,870	$457,314,490	$180,803,370
MEDICAL TRANSPORTATION	$134,162,550	$99,577,290	$34,585,260
OTHER SERVICES	$401,960,400	$303,763,950	$98,196,450
HOME HEALTH	$101,994,920	$53,973,250	$48,021,670
TOTAL FEE-FOR-SERVICE	**$20,942,768,690**	**$13,565,530,160**	**$7,377,238,530**
MANAGED CARE	$50,994,929,090	$31,207,655,330	$19,787,273,760
TWO PLAN MODEL	$33,224,633,690	$19,937,553,900	$13,287,079,790
COUNTY ORGANIZED HEALTH SYS	$10,895,223,160	$7,245,796,820	$3,649,426,340
GEOGRAPHIC MANAGED CARE	$5,453,466,210	$3,281,468,510	$2,171,997,690
PHP & OTHER MANAG. CARE	$1,421,606,040	$742,836,100	$678,769,940
DENTAL	$998,448,000	$599,824,210	$398,623,790
MENTAL HEALTH	$2,818,581,410	$2,676,215,680	$142,365,730
AUDITS/ LAWSUITS	$3,865,090	$932,560	$2,932,530
EPSDT SCREENS	$55,453,440	$29,161,990	$26,291,450
MEDICARE PAYMENTS	$4,278,782,000	$1,222,159,000	$3,056,623,000
STATE HOSP./DEVELOPMENTAL CNTRS.	$265,012,560	$265,008,160	$4,390
MISC. SERVICES	$11,239,621,690	$9,025,423,930	$2,214,197,760
RECOVERIES	-$265,697,000	-$131,961,000	-$133,736,000
GRAND TOTAL MEDI-CAL	**$91,331,764,970**	**$58,459,950,030**	**$32,871,814,940**

MEDI-CAL EXPENDITURES BY SERVICE CATEGORY
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

SERVICE CATEGORY	NOV. 2014 EST. FOR 2014-15	NOV. 2014 EST. FOR 2015-16	DOLLAR DIFFERENCE	% CHANGE
PROFESSIONAL	$8,049,783,930	$7,169,876,880	-$879,907,050	-10.93
PHYSICIANS	$1,211,239,590	$871,021,240	-$340,218,340	-28.09
OTHER MEDICAL	$4,634,021,870	$4,482,982,060	-$151,039,820	-3.26
COUNTY OUTPATIENT	$128,822,220	$124,623,920	-$4,198,300	-3.26
COMMUNITY OUTPATIENT	$2,075,700,240	$1,691,249,660	-$384,450,580	-18.52
PHARMACY	$1,019,707,130	$123,173,730	-$896,533,390	-87.92
HOSPITAL INPATIENT	$13,036,479,660	$11,313,101,110	-$1,723,378,540	-13.22
COUNTY INPATIENT	$2,504,880,420	$2,379,778,180	-$125,102,240	-4.99
COMMUNITY INPATIENT	$10,531,599,240	$8,933,322,940	-$1,598,276,300	-15.18
LONG TERM CARE	$3,500,222,280	$1,698,499,100	-$1,801,723,180	-51.47
NURSING FACILITIES	$3,248,902,810	$1,591,912,500	-$1,656,990,320	-51.00
ICF-DD	$251,319,460	$106,586,600	-$144,732,870	-57.59
OTHER SERVICES	$1,005,693,900	$638,117,870	-$367,576,030	-36.55
MEDICAL TRANSPORTATION	$345,417,310	$134,162,550	-$211,254,760	-61.16
OTHER SERVICES	$466,461,400	$401,960,400	-$64,501,000	-13.83
HOME HEALTH	$193,815,190	$101,994,920	-$91,820,270	-47.38
TOTAL FEE-FOR-SERVICE	**$26,611,886,880**	**$20,942,768,690**	**-$5,669,118,190**	**-21.30**
MANAGED CARE	$39,569,324,900	$50,994,929,090	$11,425,604,190	28.87
TWO PLAN MODEL	$25,039,523,720	$33,224,633,690	$8,185,109,960	32.69
COUNTY ORGANIZED HEALTH SYSTEMS	$9,111,917,570	$10,895,223,160	$1,783,305,580	19.57
GEOGRAPHIC MANAGED CARE	$4,277,726,340	$5,453,466,210	$1,175,739,870	27.49
PHP & OTHER MANAG. CARE	$1,140,157,260	$1,421,606,040	$281,448,780	24.69
DENTAL	$939,168,410	$998,448,000	$59,279,590	6.31
MENTAL HEALTH	$2,197,144,920	$2,818,581,410	$621,436,490	28.28
AUDITS/ LAWSUITS	$2,168,440	$3,865,090	$1,696,650	78.24
EPSDT SCREENS	$37,256,320	$55,453,440	$18,197,120	48.84
MEDICARE PAYMENTS	$4,135,900,000	$4,278,782,000	$142,882,000	3.45
STATE HOSP./DEVELOPMENTAL CNTRS.	$265,014,540	$265,012,560	-$1,980	-0.00
MISC. SERVICES	$7,752,934,710	$11,239,621,690	$3,486,686,980	44.97
RECOVERIES	-$268,768,000	-$265,697,000	$3,071,000	-1.14
GRAND TOTAL MEDI-CAL	**$81,242,031,120**	**$91,331,764,970**	**$10,089,733,850**	**12.42**
STATE FUNDS	**$27,813,303,970**	**$32,871,814,940**	**$5,058,510,970**	**18.19**

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	ELIGIBILITY						
1	FAMILY PACT PROGRAM	$532,922,000	$133,576,900	$571,452,000	$143,234,200	$38,530,000	$9,657,300
2	BREAST AND CERVICAL CANCER TREATMENT	$153,282,000	$67,558,700	$162,970,000	$71,495,500	$9,688,000	$3,936,800
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPL	$85,180,000	$38,485,000	$99,663,000	$44,631,000	$14,483,000	$6,146,000
4	MEDI-CAL ADULT INMATE PROGRAMS	$27,741,000	$0	$49,009,000	$0	$21,268,000	$0
5	MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FPL	$24,082,000	$8,428,700	$25,751,000	$9,012,850	$1,669,000	$584,150
6	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMAT	$22,374,000	$0	$31,546,000	$0	$9,172,000	$0
7	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%	$17,636,000	$8,818,000	$2,699,000	$1,349,500	-$14,937,000	-$7,468,500
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)	$1,840,000	$644,000	$1,661,000	$581,000	-$179,000	-$63,000
9	REFUGEES	$1,001,000	$1,001,000	$1,012,000	$1,012,000	$11,000	$11,000
10	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE	$740,000	$259,100	$5,747,000	$2,010,950	$5,007,000	$1,751,850
11	NEW QUALIFIED IMMIGRANTS	$0	$74,545,000	$0	$74,545,000	$0	$0
12	RESOURCE DISREGARD - % PROGRAM CHILDREN	$0	-$80,419,200	$0	-$80,419,200	$0	$0
13	SCHIP FUNDING FOR PRENATAL CARE	$0	-$83,328,700	$0	-$85,415,200	$0	-$2,086,500
14	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN	$0	$0	$0	-$39,460,000	$0	-$39,460,000
15	INCARCERATION VERIFICATION PROGRAM	-$815,000	-$407,500	-$1,301,000	-$650,500	-$486,000	-$243,000
16	PARIS-VETERANS	-$4,382,670	-$2,191,340	-$5,135,570	-$2,567,780	-$752,900	-$376,450
17	TLICP PREMIUMS	-$69,083,000	-$24,179,050	-$70,507,000	-$24,677,450	-$1,424,000	-$498,400
	ELIGIBILITY SUBTOTAL	**$792,517,330**	**$142,790,610**	**$874,566,430**	**$114,681,870**	**$82,049,100**	**-$28,108,750**
	AFFORDABLE CARE ACT						
18	ACA OPTIONAL EXPANSION	$12,583,273,000	$7,318,000	$14,319,656,000	$7,485,000	$1,736,383,000	$167,000
19	ACA MANDATORY EXPANSION	$1,603,845,000	$762,365,400	$2,020,469,000	$961,388,350	$416,624,000	$199,022,950
20	ACA EXPRESS LANE ENROLLMENT	$1,309,980,000	$14,913,750	$1,222,964,000	$15,245,750	-$87,016,000	$332,000
21	PAYMENTS TO PRIMARY CARE PHYSICIANS	$977,408,610	$25,713,260	$0	$0	-$977,408,610	-$25,713,260
22	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY	$499,157,000	$90,620,600	$689,780,000	$125,227,750	$190,623,000	$34,607,150
23	COMMUNITY FIRST CHOICE OPTION	$248,108,000	$0	$225,260,000	$0	-$22,848,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	AFFORDABLE CARE ACT						
24	ACA DELAY OF REDETERMINATIONS	$203,389,000	$81,537,950	$43,470,000	$17,836,300	-$159,919,000	-$63,701,650
25	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS	$134,679,000	$48,827,000	$95,588,000	$34,655,000	-$39,091,000	-$14,172,000
26	HEALTH INSURER FEE	$125,518,000	$56,483,000	$80,353,000	$36,159,000	-$45,165,000	-$20,324,000
27	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS	$51,916,000	$0	$51,916,000	$0	$0	$0
28	USPSTF GRADE A AND B RECOMMENDATIONS	$9,765,120	$4,882,560	$10,266,480	$5,133,240	$501,360	$250,680
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES	$0	-$85,513,000	$0	-$45,544,000	$0	$39,969,000
30	STATE-ONLY FORMER FOSTER CARE PROGRAM	$0	$230,000	$0	$0	$0	-$230,000
31	ACA MAGI SAVINGS	$0	-$17,742,000	$0	-$36,129,000	$0	-$18,387,000
32	RECOVERY AUDIT CONTRACTOR SAVINGS	$0	$0	-$2,890	-$1,440	-$2,890	-$1,440
34	MANAGED CARE DRUG REBATES	-$396,000,000	-$162,000,000	-$415,800,000	-$170,100,000	-$19,800,000	-$8,100,000
200	ACCELERATED ENROLLMENT	$715,000	$357,500	$99,000	$49,500	-$616,000	-$308,000
	AFFORDABLE CARE ACT SUBTOTAL	**$17,351,753,740**	**$827,994,020**	**$18,344,018,590**	**$951,405,450**	**$992,264,860**	**$123,411,420**
	BENEFITS						
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS	$263,397,000	$0	$291,544,000	$0	$28,147,000	$0
36	BEHAVIORAL HEALTH TREATMENT	$190,000,000	$89,000,000	$320,000,000	$151,000,000	$130,000,000	$62,000,000
37	LOCAL EDUCATION AGENCY (LEA) PROVIDERS	$128,839,000	$0	$130,839,000	$0	$2,000,000	$0
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA	$40,464,000	$20,232,000	$40,464,000	$20,232,000	$0	$0
39	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS	$34,020,000	$17,010,000	$34,020,000	$17,010,000	$0	$0
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS	$21,367,000	$2,280,000	$31,677,000	$3,846,000	$10,310,000	$1,566,000
41	DENTAL CHILDREN'S OUTREACH AGES 0-3	$6,590,000	$3,046,000	$22,251,000	$10,274,000	$15,661,000	$7,228,000
42	VOLUNTARY INPATIENT DETOXIFICATION	$25,007,000	$10,555,000	$29,458,000	$12,537,500	$4,451,000	$1,982,500
43	YOUTH REGIONAL TREATMENT CENTERS	$6,301,000	$30,000	$6,589,000	$36,000	$288,000	$6,000
44	CCT FUND TRANSFER TO CDSS AND CDDS	$4,116,000	$0	$4,330,000	$0	$214,000	$0
45	PEDIATRIC PALLIATIVE CARE WAIVER	$540,000	$270,000	$760,000	$380,000	$220,000	$110,000
46	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER	$320,000	$0	$411,000	$0	$91,000	$0

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	BENEFITS						
47	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS	$145,000	$0	$155,000	$0	$10,000	$0
48	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR	$0	$0	$18,236,000	$8,434,300	$18,236,000	$8,434,300
49	CHDP PROGRAM DENTAL REFERRAL	$0	$0	$808,000	$404,000	$808,000	$404,000
50	WOMEN'S HEALTH SERVICES	-$8,648,090	-$1,681,930	-$14,890,690	-$3,082,670	-$6,242,590	-$1,400,740
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS	-$15,647,000	-$7,823,500	-$21,481,000	-$10,740,500	-$5,834,000	-$2,917,000
201	ALLIED DENTAL PROFESSIONALS ENROLLMENT	$0	$0	$2,000,000	$925,000	$2,000,000	$925,000
202	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVING	$0	$0	-$2,293,000	-$1,146,500	-$2,293,000	-$1,146,500
	BENEFITS SUBTOTAL	**$696,810,910**	**$132,917,570**	**$894,877,310**	**$210,109,130**	**$198,066,410**	**$77,191,560**
	PHARMACY						
52	RESTORATION OF ENTERAL NUTRITION BENEFIT	$28,753,320	$14,376,660	$28,892,000	$14,446,000	$138,680	$69,340
53	PEDIATRIC MOBILE VISION PROJECT	$2,036,000	$1,018,000	$4,072,000	$2,036,000	$2,036,000	$1,018,000
54	NON FFP DRUGS	$0	$1,389,000	$0	$1,550,000	$0	$161,000
55	BCCTP DRUG REBATES	-$18,000,000	-$6,300,000	-$18,000,000	-$6,300,000	$0	$0
56	MEDICAL SUPPLY REBATES	-$31,000,000	-$15,500,000	-$31,000,000	-$15,500,000	$0	$0
57	LITIGATION SETTLEMENTS	-$40,959,000	-$40,959,000	$0	$0	$40,959,000	$40,959,000
58	FAMILY PACT DRUG REBATES	-$66,036,000	-$8,283,600	-$66,036,000	-$8,283,600	$0	$0
59	STATE SUPPLEMENTAL DRUG REBATES	-$157,745,000	-$65,819,600	-$173,570,000	-$72,407,800	-$15,825,000	-$6,588,200
60	AGED AND DISPUTED DRUG REBATES	-$196,000,000	-$97,992,000	-$170,000,000	-$84,993,200	$26,000,000	$12,998,800
61	FEDERAL DRUG REBATE PROGRAM	-$1,150,414,000	-$480,014,600	-$1,265,829,000	-$528,063,700	-$115,415,000	-$48,049,100
	PHARMACY SUBTOTAL	**-$1,629,364,680**	**-$698,085,140**	**-$1,691,471,000**	**-$697,516,300**	**-$62,106,320**	**$568,840**
	DRUG MEDI-CAL						
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT	$3,036,000	$0	$3,036,000	$0	$0	$0
67	ANNUAL RATE ADJUSTMENT	$0	$0	$5,398,000	$793,000	$5,398,000	$793,000
	DRUG MEDI-CAL SUBTOTAL	**$3,036,000**	**$0**	**$8,434,000**	**$793,000**	**$5,398,000**	**$793,000**
	MENTAL HEALTH						

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MENTAL HEALTH						
71	ELIMINATION OF STATE MAXIMUM RATES	$91,236,000	$0	$93,734,000	$0	$2,498,000	$0
72	TRANSITION OF HFP - SMH SERVICES	$42,008,000	$0	$42,520,000	$0	$512,000	$0
73	KATIE A. V. DIANA BONTA	$27,247,000	$0	$36,192,000	$0	$8,945,000	$0
74	INTERIM AND FINAL COST SETTLEMENTS - SMHS	$0	$0	$27,375,000	$23,830,000	$27,375,000	$23,830,000
75	INVESTMENT IN MENTAL HEALTH WELLNESS	$9,672,000	$0	$12,276,000	$0	$2,604,000	$0
76	HEALTHY FAMILIES - SED	$4,095,000	$0	$186,000	$0	-$3,909,000	$0
77	OVER ONE-YEAR CLAIMS	$3,585,000	$0	$942,000	$0	-$2,643,000	$0
78	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEI	$0	$0	$417,023,000	$0	$417,023,000	$0
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYM	$0	$2,397,000	$0	$0	$0	-$2,397,000
80	IMD ANCILLARY SERVICES	$0	$8,000,000	$0	$3,000,000	$0	-$5,000,000
81	CHART REVIEW	-$1,807,000	$0	-$795,000	$0	$1,012,000	$0
	MENTAL HEALTH SUBTOTAL	**$176,036,000**	**$10,397,000**	**$629,453,000**	**$26,830,000**	**$453,417,000**	**$16,433,000**
	WAIVER--MH/UCD & BTR						
82	MH/UCD & BTR—DSH PAYMENT	$1,758,626,000	$567,206,000	$1,753,168,000	$566,513,000	-$5,458,000	-$693,000
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE P(	$1,399,432,000	$699,716,000	$1,402,298,000	$701,149,000	$2,866,000	$1,433,000
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEME	$599,313,000	$299,656,500	$545,435,000	$272,717,500	-$53,878,000	-$26,939,000
85	BTR - LIHP - MCE	$365,680,000	$11,383,000	$3,412,258,000	$1,534,672,000	$3,046,578,000	$1,523,289,000
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL F	$262,741,000	$131,370,500	$344,803,000	$172,401,500	$82,062,000	$41,031,000
87	BTR—SAFETY NET CARE POOL	$242,250,000	$0	$122,917,000	$0	-$119,333,000	$0
88	MH/UCD & BTR—CCS AND GHPP	$109,910,000	$0	$6,882,000	$0	-$103,028,000	$0
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS	$92,162,000	$42,162,000	$213,326,000	$106,663,000	$121,164,000	$64,501,000
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI	$87,064,000	$1,907,000	$21,750,000	$0	-$65,314,000	-$1,907,000
91	MH/UCD & BTR—DPH INTERIM & FINAL RECONS	$84,949,000	$0	$326,815,000	$0	$241,866,000	$0
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST	$72,800,000	$0	$80,000,000	$0	$7,200,000	$0
93	BTR—DESIGNATED STATE HEALTH PROGRAMS	$14,534,000	-$331,846,000	$18,191,000	-$128,618,000	$3,657,000	$203,228,000

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COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	WAIVER--MH/UCD & BTR						
94	MH/UCD & BTR—DPH INTERIM RATE GROWTH	$47,613,070	$23,806,540	$100,260,690	$50,130,340	$52,647,610	$26,323,810
95	MH/UCD—SAFETY NET CARE POOL	$35,917,000	$0	$10,835,000	$0	-$25,082,000	$0
96	BTR—INCREASE SAFETY NET CARE POOL	$30,750,000	$0	$0	$0	-$30,750,000	$0
97	MH/UCD—STABILIZATION FUNDING	$19,500,000	$19,500,000	$0	$0	-$19,500,000	-$19,500,000
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMA	$13,744,000	$0	$0	$0	-$13,744,000	$0
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS	$12,860,000	$6,430,000	$0	$0	-$12,860,000	-$6,430,000
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT	$4,708,000	$2,354,000	$3,801,000	$1,900,500	-$907,000	-$453,500
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEA	$2,756,000	$0	$2,161,000	$0	-$595,000	$0
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE	$698,000	$0	$3,539,000	$0	$2,841,000	$0
103	MH/UCD & BTR—BCCTP	$0	-$1,980,000	$0	-$655,000	$0	$1,325,000
104	MH/UCD & BTR—DPH INTERIM RATE	$0	-$427,930,500	$0	-$450,468,500	$0	-$22,538,000
105	MH/UCD & BTR—MIA-LTC	$0	-$21,161,000	$0	-$5,152,000	$0	$16,009,000
106	BTR—INCREASE DESIGNATED STATE HEALTH PROGR	$0	-$30,750,000	$0	$0	$0	$30,750,000
107	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP	$0	$19,724,000	$0	$0	$0	-$19,724,000
108	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVEI	-$61,500,000	$0	$0	$0	$61,500,000	$0
	WAIVER--MH/UCD & BTR SUBTOTAL	**$5,196,507,070**	**$1,011,548,040**	**$8,368,439,690**	**$2,821,253,340**	**$3,171,932,610**	**$1,809,705,310**
	MANAGED CARE						
110	CCI-MANAGED CARE PAYMENTS	$5,703,559,000	$2,851,779,500	$11,265,739,000	$5,632,869,500	$5,562,180,000	$2,781,090,000
113	CCI-TRANSFER OF IHSS COSTS TO CDSS	$1,497,113,000	$1,497,113,000	$3,015,512,000	$3,015,512,000	$1,518,399,000	$1,518,399,000
114	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES	$1,432,849,000	$510,794,000	$1,909,157,000	$705,708,500	$476,308,000	$194,914,500
115	MANAGED CARE RATE RANGE IGTS	$1,102,724,000	$504,494,000	$864,408,000	$395,465,000	-$238,316,000	-$109,029,000
117	MANAGED CARE PUBLIC HOSPITAL IGTS	$384,834,000	$192,417,000	$478,650,000	$239,325,000	$93,816,000	$46,908,000
118	RETRO MC RATE ADJUSTMENTS	$357,434,000	$178,717,000	$0	$0	-$357,434,000	-$178,717,000
122	BLOOD FACTOR CARVE OUT	$37,200,000	$18,600,000	$43,900,000	$21,950,000	$6,700,000	$3,350,000
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RA	$23,288,000	$11,644,000	$0	$0	-$23,288,000	-$11,644,000

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	MANAGED CARE						
124	MANAGED CARE EXPANSION TO RURAL COUNTIES	$22,744,000	$11,372,000	$1,472,000	$736,000	-$21,272,000	-$10,636,000
126	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$0	$0
128	CAPITATED RATE ADJUSTMENT FOR FY 2015-16	$0	$0	$581,653,000	$281,211,300	$581,653,000	$281,211,300
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE	$0	$0	$0	$0	$0	$0
130	GENERAL FUND REIMBURSEMENTS FROM DPHS	$0	$0	$0	$0	$0	$0
131	EXTEND GROSS PREMIUM TAX	$0	$0	$0	$0	$0	$0
132	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMEN	$0	$0	$0	$0	$0	$0
133	FFS COSTS FOR MANAGED CARE ENROLLEES	$0	$0	$0	$0	$0	$0
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT	$0	$0	$0	$0	$0	$0
135	MCO TAX MANAGED CARE PLANS	$0	$0	$0	$0	$0	$0
136	CCI-SAVINGS AND DEFERRAL	-$4,114,361,000	-$2,057,180,500	-$8,131,660,000	-$4,065,830,000	-$4,017,299,000	-$2,008,649,500
196	ANNUAL OPEN ENROLLMENT	$0	$0	-$5,939,000	-$2,969,500	-$5,939,000	-$2,969,500
	MANAGED CARE SUBTOTAL	**$6,449,384,000**	**$3,721,750,000**	**$10,024,892,000**	**$6,225,977,800**	**$3,575,508,000**	**$2,504,227,800**
	PROVIDER RATES						
137	FQHC/RHC/CBRC RECONCILIATION PROCESS	$232,349,910	$116,174,950	$260,156,850	$130,078,420	$27,806,940	$13,903,470
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYI	$90,003,000	$45,001,500	$90,002,000	$45,001,000	-$1,000	-$500
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE	$96,034,290	$48,017,150	$177,384,520	$88,692,260	$81,350,230	$40,675,110
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT	$42,280,000	$21,140,000	$9,000,000	$4,500,000	-$33,280,000	-$16,640,000
141	AB 1629 ADD-ONS	$18,564,870	$9,282,430	$84,941,800	$42,470,900	$66,376,930	$33,188,460
142	LTC RATE ADJUSTMENT	$24,014,260	$12,007,130	$67,150,570	$33,575,280	$43,136,310	$21,568,160
143	DENTAL RETROACTIVE RATE CHANGES	$21,979,000	$9,022,600	$0	$0	-$21,979,000	-$9,022,600
144	ANNUAL MEI INCREASE FOR FQHCS/RHCS	$18,865,640	$9,432,820	$18,772,880	$9,386,440	-$92,760	-$46,380
145	GENETIC DISEASE SCREENING PROGRAM FEE INCRE/	$5,985,600	$2,992,800	$7,407,180	$3,703,590	$1,421,580	$710,790
146	HOSPICE RATE INCREASES	$6,180,240	$3,090,120	$13,035,390	$6,517,700	$6,855,150	$3,427,580
147	LONG TERM CARE QUALITY ASSURANCE FUND EXPEN	$0	$0	$0	$0	$0	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	PROVIDER RATES						
148	LABORATORY RATE METHODOLOGY CHANGE	-$14,654,480	-$7,327,240	-$55,494,030	-$27,747,020	-$40,839,550	-$20,419,780
149	NON-AB 1629 LTC RATE FREEZE	-$6,634,000	-$3,317,000	-$26,283,000	-$13,141,500	-$19,649,000	-$9,824,500
150	10% PAYMENT REDUCTION FOR LTC FACILITIES	-$9,379,110	-$4,689,550	-$20,837,000	-$10,418,500	-$11,457,890	-$5,728,950
151	REDUCTION TO RADIOLOGY RATES	-$17,681,570	-$8,840,790	-$42,212,150	-$21,106,080	-$24,530,580	-$12,265,290
152	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY	-$171,084,230	-$85,542,110	-$194,990,000	-$97,495,000	-$23,905,770	-$11,952,890
153	10% PROVIDER PAYMENT REDUCTION	-$379,313,330	-$189,656,660	-$427,714,250	-$213,857,120	-$48,400,920	-$24,200,460
	PROVIDER RATES SUBTOTAL	**-$42,489,910**	**-$23,211,850**	**-$39,679,240**	**-$19,839,620**	**$2,810,660**	**$3,372,230**
	SUPPLEMENTAL PMNTS.						
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS	$6,945,877,000	$3,122,470,000	$7,547,970,000	$3,410,589,000	$602,093,000	$288,119,000
155	HOSPITAL QAF - HOSPITAL PAYMENTS	$628,134,000	$365,696,000	$0	$0	-$628,134,000	-$365,696,000
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM	$222,242,000	$0	$61,759,000	$0	-$160,483,000	$0
157	CAPITAL PROJECT DEBT REIMBURSEMENT	$169,187,000	$74,670,500	$97,148,000	$38,670,000	-$72,039,000	-$36,000,500
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS	$165,486,000	$0	$173,833,000	$0	$8,347,000	$0
159	NDPH IGT SUPPLEMENTAL PAYMENTS	$140,000,000	$70,000,000	$70,000,000	$35,000,000	-$70,000,000	-$35,000,000
160	FFP FOR LOCAL TRAUMA CENTERS	$103,600,000	$51,800,000	$80,200,000	$40,100,000	-$23,400,000	-$11,700,000
161	CERTIFICATION PAYMENTS FOR DP-NFS	$95,488,000	$0	$46,924,000	$0	-$48,564,000	$0
162	IGT PAYMENTS FOR HOSPITAL SERVICES	$15,000,000	$7,500,000	$15,000,000	$7,500,000	$0	$0
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS	$11,813,000	$0	$159,938,000	$0	$148,125,000	$0
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH	$10,000,000	$5,000,000	$10,000,000	$5,000,000	$0	$0
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH	$8,000,000	$4,000,000	$8,000,000	$4,000,000	$0	$0
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS	$4,000,000	$0	$3,600,000	$0	-$400,000	$0
	SUPPLEMENTAL PMNTS. SUBTOTAL	**$8,518,827,000**	**$3,701,136,500**	**$8,274,372,000**	**$3,540,859,000**	**-$244,455,000**	**-$160,277,500**
	OTHER						
173	ARRA HITECH - PROVIDER PAYMENTS	$217,513,000	$0	$114,822,000	$0	-$102,691,000	$0
175	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDI	$114,643,000	$0	$122,158,000	$0	$7,515,000	$0

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

COMPARISON OF FISCAL IMPACTS OF REGULAR POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
176	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS	$68,216,000	$34,108,000	$66,980,000	$33,490,000	-$1,236,000	-$618,000
180	AUDIT SETTLEMENTS	$33,206,000	$33,206,000	$0	$0	-$33,206,000	-$33,206,000
181	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS	$16,415,000	$6,481,000	$16,415,000	$6,481,000	$0	$0
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS	$11,734,000	$3,520,000	$0	$0	-$11,734,000	-$3,520,000
184	OVERTIME FOR IHSS PROVIDERS	$4,000,000	$2,000,000	$4,000,000	$2,000,000	$0	$0
186	CDDS DENTAL SERVICES	$2,016,000	$2,016,000	$2,016,000	$2,016,000	$0	$0
188	INDIAN HEALTH SERVICES	$1,158,000	-$10,616,500	$2,317,000	-$10,616,500	$1,159,000	$0
189	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER	$209,000	$104,500	$325,000	$162,500	$116,000	$58,000
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE	$0	$0	$0	$0	$0	$0
191	CIGARETTE AND TOBACCO SURTAX FUNDS	$0	$0	$0	$0	$0	$0
192	CLPP FUND	$0	$0	$0	$0	$0	$0
193	CCI-TRANSFER OF IHSS COSTS TO DHCS	$0	$0	$0	$0	$0	$0
194	IHSS REDUCTION IN SERVICE HOURS	-$213,426,000	$0	$0	$0	$213,426,000	$0
199	WPCS WORKERS' COMPENSATION	$2,264,000	$1,132,000	$2,332,000	$1,166,000	$68,000	$34,000
	OTHER SUBTOTAL	**$257,948,000**	**$71,951,000**	**$331,365,000**	**$34,699,000**	**$73,417,000**	**-$37,252,000**
	GRAND TOTAL	**$37,770,965,450**	**$8,899,187,750**	**$46,019,267,780**	**$13,209,252,670**	**$8,248,302,320**	**$4,310,064,920**

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

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

SERVICE CATEGORY	PA-OAS	PA-AB	PA-ATD	PA-AFDC	LT-OAS	LT-AB
PHYSICIANS	$2,262,580	$239,050	$10,694,010	$53,112,070	$369,120	$6,060
OTHER MEDICAL	$23,174,190	$3,350,550	$137,024,600	$401,167,390	$3,343,080	$106,060
COUNTY OUTPATIENT	$125,110	$15,270	$1,609,130	$2,152,750	$42,140	$150
COMMUNITY OUTPATIENT	$2,135,580	$485,250	$32,002,140	$32,667,660	$171,470	$1,400
PHARMACY	-$12,261,410	-$7,951,650	-$544,856,440	$114,814,610	-$5,396,290	-$85,030
COUNTY INPATIENT	$4,145,920	$468,410	$41,588,820	$39,272,720	$1,613,310	$11,970
COMMUNITY INPATIENT	$37,140,490	$4,612,840	$221,231,980	$371,302,970	$8,607,810	$111,300
NURSING FACILITIES	$140,479,660	$5,978,500	$207,956,280	$4,142,320	$662,175,720	$2,713,350
ICF-DD	$156,890	$2,031,730	$50,664,870	$351,140	$7,346,740	$736,190
MEDICAL TRANSPORTATION	$5,259,590	$1,075,590	$13,803,100	$4,158,930	$1,548,910	$32,570
OTHER SERVICES	$21,009,010	$3,999,490	$79,880,940	$41,995,850	$20,902,430	$69,050
HOME HEALTH	$171,690	$2,686,600	$39,839,790	$6,359,130	$7,320	$0
FFS SUBTOTAL	**$223,799,310**	**$16,991,630**	**$291,439,220**	**$1,071,497,550**	**$700,731,760**	**$3,703,070**
DENTAL	$37,900,280	$1,918,160	$88,575,800	$139,035,370	$4,017,490	$19,650
TWO PLAN MODEL	$1,409,627,590	$160,776,740	$9,789,120,420	$1,828,837,580	$0	$0
COUNTY ORGANIZED HEALTH SYSTEMS	$386,962,440	$31,435,290	$1,668,755,550	$452,726,060	$900,095,450	$2,010,160
GEOGRAPHIC MANAGED CARE	$235,117,770	$29,041,780	$1,705,194,420	$297,189,990	$0	$0
PHP & OTHER MANAG. CARE	$210,936,550	$5,396,600	$167,725,790	$145,107,830	$9,373,150	$0
EPSDT SCREENS	$0	$0	$0	$12,023,970	$0	$0
MEDICARE PAYMENTS	$1,470,734,710	$44,132,120	$1,387,187,760	$0	$148,140,920	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$10,718,440	$538,370	$25,303,350	$37,490,070	$1,101,210	$24,470
MISC. SERVICES	$775,417,600	$39,452,670	$3,699,027,900	$640,340	$8,340	$0
NON-FFS SUBTOTAL	**$4,537,415,380**	**$312,691,740**	**$18,530,890,990**	**$2,913,051,210**	**$1,062,736,560**	**$2,054,290**
TOTAL DOLLARS (1)	**$4,761,214,700**	**$329,683,370**	**$18,822,330,210**	**$3,984,548,760**	**$1,763,468,320**	**$5,757,360**
ELIGIBLES ***	**438,200**	**21,600**	**1,034,100**	**1,531,700**	**44,800**	**200**
ANNUAL $/ELIGIBLE	**$10,865**	**$15,263**	**$18,202**	**$2,601**	**$39,363**	**$28,787**
AVG. MO. $/ELIGIBLE	**$905**	**$1,272**	**$1,517**	**$217**	**$3,280**	**$2,399**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

SERVICE CATEGORY	LT-ATD	POV 250	MN-OAS	MN-AB	MN-ATD	MN-AFDC
PHYSICIANS	$607,340	$20,807,610	$2,244,240	$40,040	$6,550,310	$253,508,780
OTHER MEDICAL	$2,670,030	$156,567,500	$30,628,390	$367,180	$44,743,260	$1,086,737,590
COUNTY OUTPATIENT	$94,110	$910,790	$316,630	$8,770	$1,595,650	$22,426,150
COMMUNITY OUTPATIENT	$233,550	$32,078,640	$2,383,570	$17,630	$8,555,380	$135,105,920
PHARMACY	-$10,120,250	$82,664,760	-$13,747,250	-$152,240	-$53,215,870	$218,453,830
COUNTY INPATIENT	$13,641,480	$6,558,870	$13,480,170	$440,430	$111,042,880	$309,697,050
COMMUNITY INPATIENT	$13,381,520	$103,634,770	$26,911,230	$354,500	$121,907,560	$1,688,123,290
NURSING FACILITIES	$205,939,350	$131,890	$72,320,040	$232,850	$23,928,820	$20,053,510
ICF-DD	$36,460,460	$18,530	$200,490	$0	$3,801,230	$153,570
MEDICAL TRANSPORTATION	$809,940	$833,020	$4,975,750	$77,420	$8,076,900	$15,300,680
OTHER SERVICES	$4,249,220	$14,442,380	$14,957,900	$71,450	$16,936,290	$110,019,760
HOME HEALTH	$14,610	$4,071,960	$149,780	$0	$16,054,650	$10,993,310
FFS SUBTOTAL	**$267,981,360**	**$422,720,710**	**$154,820,950**	**$1,458,030**	**$309,977,070**	**$3,870,573,430**
DENTAL	$1,282,520	$116,560,290	$28,551,770	$52,060	$16,846,520	$353,550,760
TWO PLAN MODEL	$0	$856,283,490	$1,810,504,140	$4,645,140	$1,011,803,690	$3,647,226,350
COUNTY ORGANIZED HEALTH SYSTEMS	$318,481,860	$432,549,690	$383,073,610	$600,350	$401,179,330	$1,346,132,080
GEOGRAPHIC MANAGED CARE	$0	$183,101,500	$200,159,650	$171,970	$168,486,430	$594,229,220
PHP & OTHER MANAG. CARE	$308,860	$82,520,530	$178,033,220	$377,530	$30,513,850	$328,617,440
EPSDT SCREENS	$0	$7,669,010	$0	$0	$0	$29,808,330
MEDICARE PAYMENTS	$41,799,390	$0	$729,609,050	$0	$384,678,020	$72,500,030
STATE HOSP./DEVELOPMENTAL CNTRS.	$342,600	$0	$8,858,620	$24,470	$4,722,970	$100,748,450
MISC. SERVICES	$2,680	-$70,507,000	$609,055,220	$1,090,860	$696,512,800	$1,828,810
NON-FFS SUBTOTAL	**$362,217,910**	**$1,608,177,500**	**$3,947,845,280**	**$6,962,380**	**$2,714,743,600**	**$6,474,641,480**
TOTAL DOLLARS (1)	**$630,199,270**	**$2,030,898,210**	**$4,102,666,230**	**$8,420,410**	**$3,024,720,670**	**$10,345,214,920**
ELIGIBLES ***	**14,200**	**971,800**	**370,300**	**500**	**197,400**	**4,116,500**
ANNUAL $/ELIGIBLE	**$44,380**	**$2,090**	**$11,079**	**$16,841**	**$15,323**	**$2,513**
AVG. MO. $/ELIGIBLE	**$3,698**	**$174**	**$923**	**$1,403**	**$1,277**	**$209**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

SERVICE CATEGORY	MI-C	MI-A	REFUGEE	OBRA	POV 185	POV 133
PHYSICIANS	$30,623,750	$39,216,430	$330,410	$41,047,990	$197,340,530	$4,299,730
OTHER MEDICAL	$126,469,430	$1,439,578,310	$1,747,540	$61,452,160	$305,956,590	$54,032,810
COUNTY OUTPATIENT	$1,782,020	$2,340,090	$38,670	$11,095,420	$4,226,980	$232,780
COMMUNITY OUTPATIENT	$15,640,900	$9,522,150	$128,360	$15,017,820	$34,709,030	$4,574,150
PHARMACY	$55,592,350	$130,152,680	$572,240	$23,567,640	$15,264,430	$6,554,370
COUNTY INPATIENT	$22,837,620	$37,447,720	$20,960	$166,052,050	$120,477,890	$881,640
COMMUNITY INPATIENT	$116,477,410	$136,938,530	$628,210	$242,982,770	$760,147,970	$27,309,550
NURSING FACILITIES	$6,190,220	$32,055,730	$43,930	$19,719,210	$420,510	$733,010
ICF-DD	$1,515,980	$733,980	$0	$258,370	$0	$0
MEDICAL TRANSPORTATION	$1,897,030	$3,892,420	$11,890	$6,161,050	$2,306,160	$271,900
OTHER SERVICES	$13,131,100	$17,779,880	$14,420	$4,304,460	$14,640,710	$5,137,990
HOME HEALTH	$14,810,540	$46,040	$200	$16,290	$1,697,740	$1,091,480
FFS SUBTOTAL	**$406,968,340**	**$1,849,703,970**	**$3,536,830**	**$591,675,230**	**$1,457,188,550**	**$105,119,420**
DENTAL	$27,567,190	$141,444,110	$223,030	$200,350	$1,026,210	$16,608,950
TWO PLAN MODEL	$62,401,970	$7,650,297,760	$1,196,980	$0	$162,317,460	$206,786,850
COUNTY ORGANIZED HEALTH SYSTEMS	$48,792,470	$3,279,976,020	$259,140	$6,820,790	$65,564,800	$101,106,450
GEOGRAPHIC MANAGED CARE	$9,664,950	$1,213,912,380	$522,280	$0	$27,112,710	$50,657,400
PHP & OTHER MANAG. CARE	$8,069,690	$31,539,610	$13,550	$0	$12,792,960	$17,085,010
EPSDT SCREENS	$1,712,980	$0	$0	$0	$0	$1,668,860
MEDICARE PAYMENTS	$0	$0	$0	$0	$0	$0
STATE HOSP./DEVELOPMENTAL CNTRS.	$5,995,480	$53,934,800	$0	$73,410	$6,729,620	$0
MISC. SERVICES	$31,716,550	$339,281,580	$0	$0	$98,320	$41,730
NON-FFS SUBTOTAL	**$195,921,280**	**$12,710,386,270**	**$2,214,980**	**$7,094,550**	**$275,642,080**	**$393,955,240**
TOTAL DOLLARS (1)	**$602,889,620**	**$14,560,090,240**	**$5,751,810**	**$598,769,780**	**$1,732,830,630**	**$499,074,670**
ELIGIBLES ***	**244,600**	**2,204,200**	**2,500**	**184,400**	**275,200**	**226,800**
ANNUAL $/ELIGIBLE	**$2,465**	**$6,606**	**$2,301**	**$3,247**	**$6,297**	**$2,201**
AVG. MO. $/ELIGIBLE	**$205**	**$550**	**$192**	**$271**	**$525**	**$183**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

SERVICE CATEGORY	POV 100	TOTAL
PHYSICIANS	$7,465,770	**$670,765,800**
OTHER MEDICAL	$60,025,500	**$3,939,142,170**
COUNTY OUTPATIENT	$558,770	**$49,571,400**
COMMUNITY OUTPATIENT	$7,412,960	**$332,843,570**
PHARMACY	$13,654,230	**$13,504,710**
COUNTY INPATIENT	$4,644,960	**$894,324,860**
COMMUNITY INPATIENT	$51,018,490	**$3,932,823,210**
NURSING FACILITIES	$557,270	**$1,405,772,170**
ICF-DD	$20,620	**$104,450,770**
MEDICAL TRANSPORTATION	$469,000	**$70,961,870**
OTHER SERVICES	$10,383,940	**$393,926,290**
HOME HEALTH	$1,858,710	**$99,869,840**
FFS SUBTOTAL	**$158,070,210**	**$11,907,956,660**
DENTAL	$21,017,780	**$996,398,300**
TWO PLAN MODEL	$304,696,980	**$28,906,523,140**
COUNTY ORGANIZED HEALTH SYSTEMS	$135,173,140	**$9,961,694,680**
GEOGRAPHIC MANAGED CARE	$74,718,620	**$4,789,281,080**
PHP & OTHER MANAG. CARE	$26,141,510	**$1,254,553,700**
EPSDT SCREENS	$2,568,690	**$55,451,840**
MEDICARE PAYMENTS	$0	**$4,278,782,000**
STATE HOSP./DEVELOPMENTAL CNTRS.	$8,393,660	**$265,000,000**
MISC. SERVICES	$52,790	**$6,123,721,170**
NON-FFS SUBTOTAL	**$572,763,180**	**$56,631,405,900**
TOTAL DOLLARS (1)	**$730,833,390**	**$68,539,362,560**
ELIGIBLES ***	**342,500**	**12,221,500**
ANNUAL $/ELIGIBLE	**$2,134**	**$5,608**
AVG. MO. $/ELIGIBLE	**$178**	**$467**

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

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

Excluded policy changes: 70. Refer to page following report for listing.

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 70

1	FAMILY PACT PROGRAM
2	BREAST AND CERVICAL CANCER TREATMENT
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPL
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	SCHIP FUNDING FOR PRENATAL CARE
14	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
31	ACA MAGI SAVINGS
50	WOMEN'S HEALTH SERVICES
54	NON FFP DRUGS
58	FAMILY PACT DRUG REBATES
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
78	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
82	MH/UCD & BTR—DSH PAYMENT
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
85	BTR - LIHP - MCE
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
87	BTR—SAFETY NET CARE POOL
88	MH/UCD & BTR—CCS AND GHPP
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
93	BTR—DESIGNATED STATE HEALTH PROGRAMS
95	MH/UCD—SAFETY NET CARE POOL
96	BTR—INCREASE SAFETY NET CARE POOL
97	MH/UCD—STABILIZATION FUNDING
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 70

101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
103	MH/UCD & BTR—BCCTP
104	MH/UCD & BTR—DPH INTERIM RATE
105	MH/UCD & BTR—MIA-LTC
106	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
107	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
108	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS
113	CCI-TRANSFER OF IHSS COSTS TO CDSS
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE
130	GENERAL FUND REIMBURSEMENTS FROM DPHS
131	EXTEND GROSS PREMIUM TAX
132	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
143	DENTAL RETROACTIVE RATE CHANGES
147	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
155	HOSPITAL QAF - HOSPITAL PAYMENTS
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM
157	CAPITAL PROJECT DEBT REIMBURSEMENT
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
159	NDPH IGT SUPPLEMENTAL PAYMENTS
160	FFP FOR LOCAL TRAUMA CENTERS
161	CERTIFICATION PAYMENTS FOR DP-NFS
162	IGT PAYMENTS FOR HOSPITAL SERVICES
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
173	ARRA HITECH - PROVIDER PAYMENTS

FISCAL YEAR 2015-16 COST PER ELIGIBLE BASED ON NOVEMBER 2014 ESTIMATE

EXCLUDED POLICY CHANGES: 70

177	MEDI-CAL TCM PROGRAM
180	AUDIT SETTLEMENTS
186	CDDS DENTAL SERVICES
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
191	CIGARETTE AND TOBACCO SURTAX FUNDS
192	CLPP FUND
193	CCI-TRANSFER OF IHSS COSTS TO DHCS
200	ACCELERATED ENROLLMENT

Estimated Average Monthly Certified Eligibles
November 2014 Estimate
Fiscal Years 2013-2014, 2014-2015 & 2015-2016

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

	2013-2014	2014-2015	2015-2016	13-14 To 14-15 % Change	14-15 To 15-16 % Change
Public Assistance	**2,862,300**	**2,993,300**	**3,025,600**	**4.58%**	**1.08%**
Aged	420,800	432,200	438,200	2.71%	1.39%
Blind	21,400	21,600	21,600	0.93%	0.00%
Disabled	994,900	1,017,500	1,034,100	2.27%	1.63%
Families	1,425,200	1,522,000	1,531,700	6.79%	0.64%
Long Term	**60,400**	**59,300**	**59,200**	**-1.82%**	**-0.17%**
Aged	45,600	44,900	44,800	-1.54%	-0.22%
Blind	200	200	200	0.00%	0.00%
Disabled	14,600	14,200	14,200	-2.74%	0.00%
Medically Needy [1]	**4,025,400**	**4,534,400**	**4,672,900**	**12.64%**	**3.05%**
Aged	315,200	351,100	363,200	11.39%	3.45%
Blind	600	600	500	0.00%	-16.67%
Disabled	174,300	184,500	192,700	5.85%	4.44%
Families [2]	3,535,300	3,998,200	4,116,500	13.09%	2.96%
Medically Indigent	**924,800**	**2,414,200**	**2,448,800**	**161.05%**	**1.43%**
Children	244,300	241,500	244,600	-1.15%	1.28%
Adults	680,500	2,172,700	2,204,200	219.28%	1.45%
Other	**1,632,900**	**1,971,500**	**2,015,000**	**20.74%**	**2.21%**
Refugees	2,400	2,500	2,500	4.17%	0.00%
Undocumented Persons [3]	104,000	184,100	184,400	77.02%	0.16%
185% Poverty [4]	201,700	266,000	275,200	31.88%	3.46%
133% Poverty	177,800	220,300	226,800	23.90%	2.95%
100% Poverty	233,000	334,600	342,500	43.61%	2.36%
250% Poverty	903,100	952,200	971,800	5.44%	2.06%
QMB	10,900	11,800	11,800	8.26%	0.00%
GRAND TOTAL [5]	**9,505,800**	**11,972,700**	**12,221,500**	**25.95%**	**2.08%**

Note: Graphs of eligibles represent base projections only and do not reflect estimated impact of policy changes.
***** See CL Page B reflecting impact of Policy Changes.**

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

[2] The 1931(b) category of eligibility is included in MN-Families and PA-Families.

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

	2013-2014	2014-2015	2015-2016
Total Undoc. Persons	817,100	823,500	823,500

[4] Includes the following presumptive eligibility for pregnant women program eligibles:

	2013-2014	2014-2015	2015-2016
Presumptive Eligibility	26,800	29,000	29,000

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

November 2014 Medi-Cal Estimate
Caseload Changes Identified in Policy Changes
(Portion not in the base estimate)

Policy Change	Budget Aid Category	Caseload Change Average Monthly Eligibles *not* in the Base Estimate 2013-14	2014-15	2015-16
PC 5 Medi-Cal Access Program Infants 250-300%	MI-C	0	6,075	5,646
	Total	**0**	**6,075**	**5,646**
PC 4 Medi-Cal Adult Inmate Programs	LT-OAS	10	10	10
	MN-OAS	88	88	88
	MN-ATD	15	15	15
	MI-C	7	7	7
	POV 185	8	8	8
	Total	**127**	**127**	**127**
PC 6 Medi-Cal Inpt Hosp Costs - Juvenile Inmates	MI-C	109	505	505
	Total	**109**	**505**	**505**
PC 15 Incarceration Verfication Program	MN-AFDC	0	(12)	(13)
	PA-ATD	0	(1)	(1)
	PA-AFDC	0	(5)	(5)
	MI-C	0	(1)	(1)
	POV 100	0	(1)	(1)
	Total	**0**	**(19)**	**(21)**
PC 16 PARIS-Veterans	LTC-OAS	0	(2)	(2)
	MN-OAS	0	(3)	(3)
	MN-ATD	0	(3)	(3)
	MN-AFDC	0	(5)	(5)
	PA-AFDC	0	(1)	(1)
	MI-A	0	(1)	(1)
	Total	**0**	**(13)**	**(13)**
PC 18 ACA Optional Expansion	MI-A	0	1,967,870	2,012,616
	Total	**0**	**1,967,870**	**2,012,616**
PC 19 ACA Mandatory Expansion	MN-AFDC	0	223,902	319,615
	MI-C	0	13,905	19,849
	MI-A	0	120	172
	POV 185	0	9,846	14,055
	POV 133	0	10,128	14,458
	POV 100	0	11,245	16,052
	Total	**0**	**269,146**	**384,199**
PC 27 ACA Exp-Adult Inmates Inpt. Hosp. Costs	MI-A	0	467	467
	Total	**0**	**467**	**467**
PC 22 ACA Hospital Presumptive Eligibility	PA-AB	0	9	8
	PA-ATD	0	404	384
	PA-AFDC	0	583	555
	MN-ATD	0	71	68
	MN-AFDC	0	1,422	1,354
	MI-C	0	443	422
	MI-A	0	32,895	31,327
	POV 185	0	63	60
	POV 133	0	64	61
	POV 100	0	71	68
	Total	**0**	**36,024**	**34,307**

November 2014 Medi-Cal Estimate
Caseload Changes Identified in Policy Changes
(Portion not in the base estimate)

Policy Change	Budget Aid Category	Caseload Change Average Monthly Eligibles *not* in the Base Estimate 2013-14	2014-15	2015-16
PC 3 Medi-Cal Access Program Mothers 200-300%	MI-A	0	4,708	5,346
	Total	**0**	**4,708**	**5,346**
PC 10 Medi-Cal Access Program 30 Week Change	POV 185	0	19	75
	Total	**0**	**19**	**75**
PC 25 ACA Expansion-New Qualified Immigrants	PA-OAS	0	1,004	651
	PA-AB	0	52	34
	PA-ATD	0	2,403	1,558
	PA-AFDC	0	3,471	2,250
	LT-OAS	0	113	73
	LT-ATD	0	36	23
	MN-OAS	0	723	469
	MN-AB	0	1	1
	MN-ATD	0	425	276
	MN-AFDC	0	8,466	5,489
	MI-C	0	526	341
	MI-A	0	5	3
	POV 185	0	372	241
	POV 133	0	383	248
	POV 100	0	425	276
	Total	**0**	**18,407**	**11,934**
PC 20 ACA Express Lane Enrollment	PA-AB	0	85	79
	PA-ATD	0	3,940	3,678
	PA-AFDC	0	5,690	5,312
	MN-AB	0	2	2
	MN-ATD	0	697	651
	MN-AFDC	0	13,879	12,957
	MI-C	0	862	805
	MI-A	0	165,367	153,052
	POV 185	0	610	570
	POV 133	0	628	586
	POV 100	0	697	651
	Total	**0**	**192,458**	**178,342**
Total by aid code group	***By Aid Category Group***			
	PA Aged	0	1,004	651
	PA Blind	0	146	121
	PA Disabled	0	6,746	5,619
	PA AFDC (Families)	0	9,743	8,112
	LT Aged	10	122	82
	LT Disabled	0	36	23
	MN Aged	88	808	554
	MN Blind	0	4	3
	MN Disabled	15	1,206	1,006
	MN AFDC (Families)	0	247,652	339,397
	MI Adult	0	2,171,432	2,202,982
	MI Children	116	22,321	27,573
	185% Poverty	8	10,917	15,007
	133% Poverty	0	11,203	15,354
	100% Poverty	0	12,438	17,045
	Total	**236**	**2,495,777**	**2,633,532**

Notes: MN AFDC includes the 1931(b) Program.
Family PACT, Healthy Families (7X, 8X) and BCCTP eligibles are not included in caseload chart.

Comparison of Average Monthly Certified Eligibles
November 2014 Estimate
Fiscal Year 2014-15

(With Estimated Impact of Eligibility Policy Changes)

	Appropriaton 2014-2015	November 2014 2014-2015	% Change
Public Assistance	**2,933,700**	**2,993,300**	**2.03%**
Aged	426,500	432,200	1.34%
Blind	21,700	21,600	-0.46%
Disabled	1,030,500	1,017,500	-1.26%
Families	1,455,000	1,522,000	4.60%
Long Term	**61,000**	**59,300**	**-2.79%**
Aged	46,000	44,900	-2.39%
Blind	200	200	0.00%
Disabled	14,800	14,200	-4.05%
Medically Needy [1]	**4,665,000**	**4,534,400**	**-2.80%**
Aged	321,800	351,100	9.11%
Blind	600	600	0.00%
Disabled	187,100	184,500	-1.39%
Families	4,155,500	3,998,200	-3.79%
Medically Indigent	**2,091,100**	**2,414,200**	**15.45%**
Children	266,400	241,500	-9.35%
Adults	1,824,700	2,172,700	19.07%
Other	**1,749,700**	**1,971,500**	**12.68%**
Refugees	2,600	2,500	-3.85%
Undocumented Persons	120,500	184,100	52.78%
185% Poverty	229,200	266,000	16.06%
133% Poverty	206,000	220,300	6.94%
100% Poverty	260,600	334,600	28.40%
250% Poverty	919,500	952,200	3.56%
QMB	11,300	11,800	4.42%
GRAND TOTAL	**11,500,500**	**11,972,700**	**4.11%**

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

Estimated Average Monthly Certified Eligibles
November 2014 Estimate
Fiscal Years 2013-2014, 2014-2015 & 2015-2016

Managed Care (With Estimated Impact of Eligibility Policy Changes)***	2013-2014	2014-2015	2015-2016	13-14 To 14-15 % Change	14-15 To 15-16 % Change
Public Assistance	**2,056,290**	**2,241,670**	**2,281,210**	**9.02%**	**1.76%**
Aged	120,560	157,880	166,950	30.96%	5.74%
Blind	11,360	12,440	12,570	9.51%	1.05%
Disabled	651,660	700,070	723,540	7.43%	3.35%
Families	1,272,710	1,371,280	1,378,150	7.74%	0.50%
Long Term	**12,310**	**15,100**	**15,170**	**22.66%**	**0.46%**
Aged	9,000	11,290	11,340	25.44%	0.44%
Blind	20	30	30	50.00%	0.00%
Disabled	3,290	3,780	3,800	14.89%	0.53%
Medically Needy [1]	**2,778,570**	**3,200,000**	**3,318,090**	**15.17%**	**3.69%**
Aged	143,960	171,170	179,470	18.90%	4.85%
Blind	300	290	290	-3.33%	0.00%
Disabled	82,050	92,890	97,000	13.21%	4.42%
Families [2]	2,552,260	2,935,650	3,041,330	15.02%	3.60%
Medically Indigent	**444,200**	**1,637,720**	**1,953,930**	**268.69%**	**19.31%**
Children	58,300	74,990	79,850	28.63%	6.48%
Adults	385,900	1,562,730	1,874,080	304.96%	19.92%
Other	**1,187,840**	**1,359,040**	**1,385,460**	**14.41%**	**1.94%**
Refugees	1,360	1,360	1,380	0.00%	1.47%
Undocumented Persons	610	1,060	1,070	73.77%	0.94%
185% Poverty	58,810	93,030	97,650	58.19%	4.97%
133% Poverty	150,330	185,260	191,750	23.24%	3.50%
100% Poverty	183,980	261,680	272,540	42.23%	4.15%
250% Poverty	792,750	816,650	821,070	3.01%	0.54%
GRAND TOTAL [3]	**6,479,210**	**8,453,530**	**8,953,860**	**30.47%**	**5.92%**
Percent of Statewide	**68.16%**	**70.61%**	**73.26%**		

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

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

[2] The 1931(b) category of eligibility is included in MN-Families and PA-Families.

[3] Eligibles enrolled or estimated to be enrolled in a medical Managed Care plan.

Estimated Average Monthly Certified Eligibles
November 2014 Estimate
Fiscal Years 2013-2014, 2014-2015 & 2015-2016

Fee-For-Service

(With Estimated Impact of Eligibility Policy Changes)*

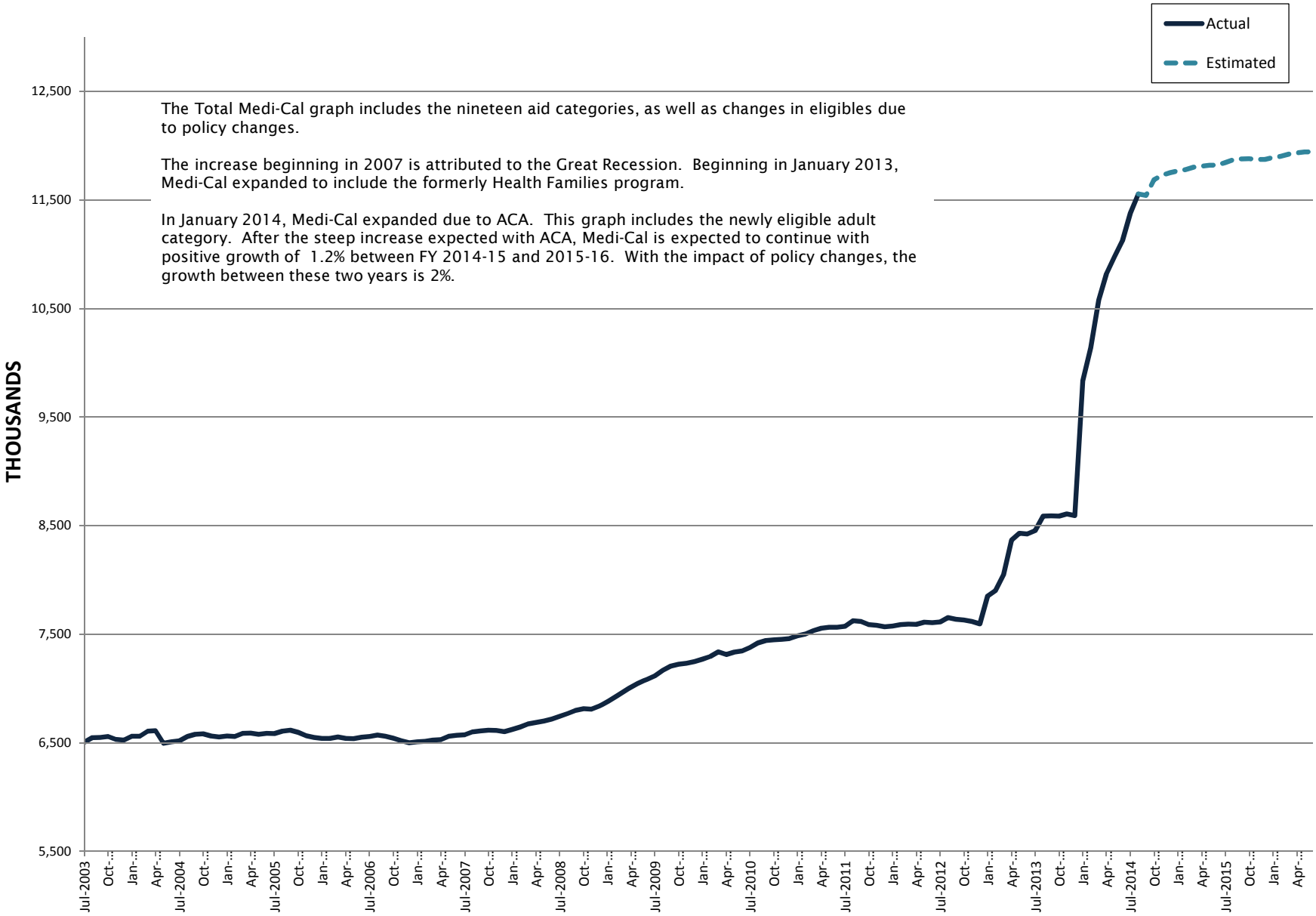
	2013-2014	2014-2015	2015-2016	13-14 To 14-15 % Change	14-15 To 15-16 % Change
Public Assistance	**806,010**	**751,630**	**744,390**	**-6.75%**	**-0.96%**
Aged	300,240	274,320	271,250	-8.63%	-1.12%
Blind	10,040	9,160	9,030	-8.76%	-1.42%
Disabled	343,240	317,430	310,560	-7.52%	-2.16%
Families	152,490	150,720	153,550	-1.16%	1.88%
Long Term	**48,090**	**44,200**	**44,030**	**-8.09%**	**-0.38%**
Aged	36,600	33,610	33,460	-8.17%	-0.45%
Blind	180	170	170	-5.56%	0.00%
Disabled	11,310	10,420	10,400	-7.87%	-0.19%
Medically Needy [1]	**1,246,830**	**1,334,400**	**1,354,810**	**7.02%**	**1.53%**
Aged	171,240	179,930	183,730	5.07%	2.11%
Blind	300	310	210	3.33%	-32.26%
Disabled	92,250	91,610	95,700	-0.69%	4.46%
Families [2]	983,040	1,062,550	1,075,170	8.09%	1.19%
Medically Indigent	**480,600**	**776,480**	**494,870**	**61.56%**	**-36.27%**
Children	186,000	166,510	164,750	-10.48%	-1.06%
Adults	294,600	609,970	330,120	107.05%	-45.88%
Other	**445,060**	**612,460**	**629,540**	**37.61%**	**2.79%**
Refugees	1,040	1,140	1,120	9.62%	-1.75%
Undocumented Persons	103,390	183,040	183,330	77.04%	0.16%
185% Poverty	142,890	172,970	177,550	21.05%	2.65%
133% Poverty	27,470	35,040	35,050	27.56%	0.03%
100% Poverty	49,020	72,920	69,960	48.76%	-4.06%
250% Poverty	110,350	135,550	150,730	22.84%	11.20%
QMB	10,900	11,800	11,800	8.26%	0.00%
GRAND TOTAL	**3,026,590**	**3,519,170**	**3,267,640**	**16.28%**	**-7.15%**
Percent of Statewide	**31.84%**	**29.39%**	**26.74%**		

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

[1] Includes Medically Needy with No Share-of-Cost and Medically Needy with a Share-of-Cost.

[2] The 1931(b) category of eligibility is included in MN-Families and PA-Families.

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: TOTAL MEDI-CAL

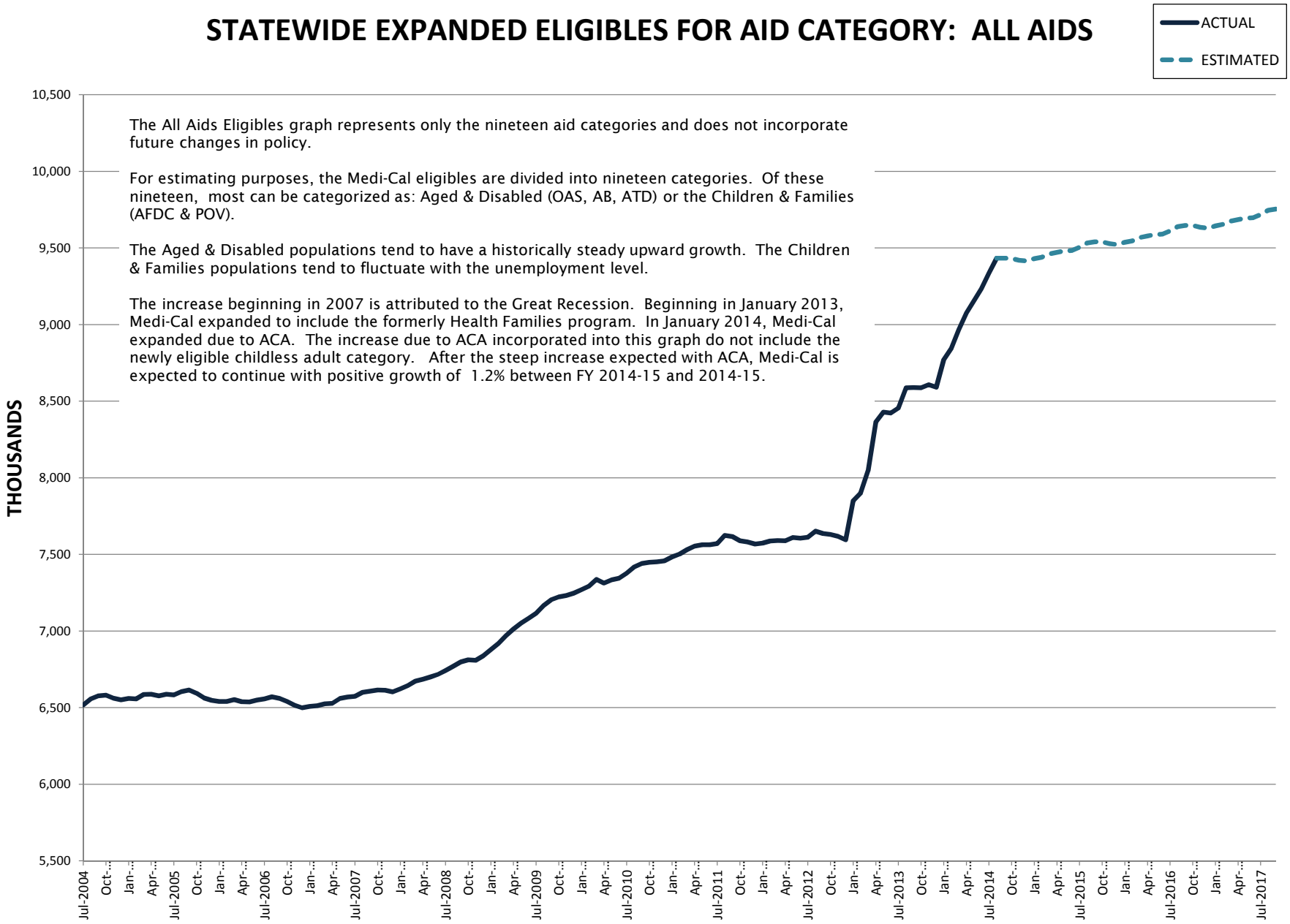


The Total Medi-Cal graph includes the nineteen aid categories, as well as changes in eligibles due to policy changes.

The increase beginning in 2007 is attributed to the Great Recession. Beginning in January 2013, Medi-Cal expanded to include the formerly Health Families program.

In January 2014, Medi-Cal expanded due to ACA. This graph includes the newly eligible adult category. After the steep increase expected with ACA, Medi-Cal is expected to continue with positive growth of 1.2% between FY 2014-15 and 2015-16. With the impact of policy changes, the growth between these two years is 2%.

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: ALL AIDS

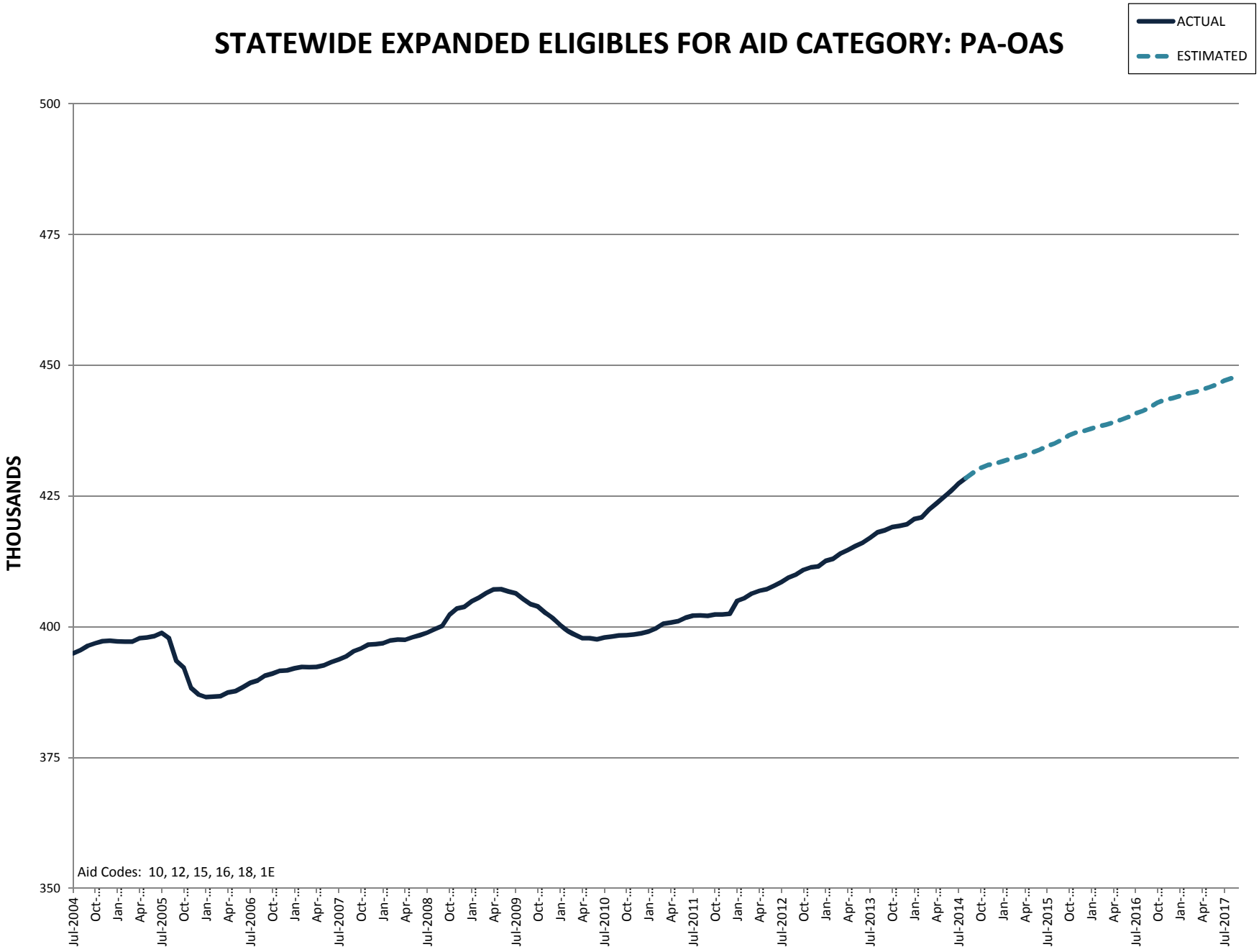


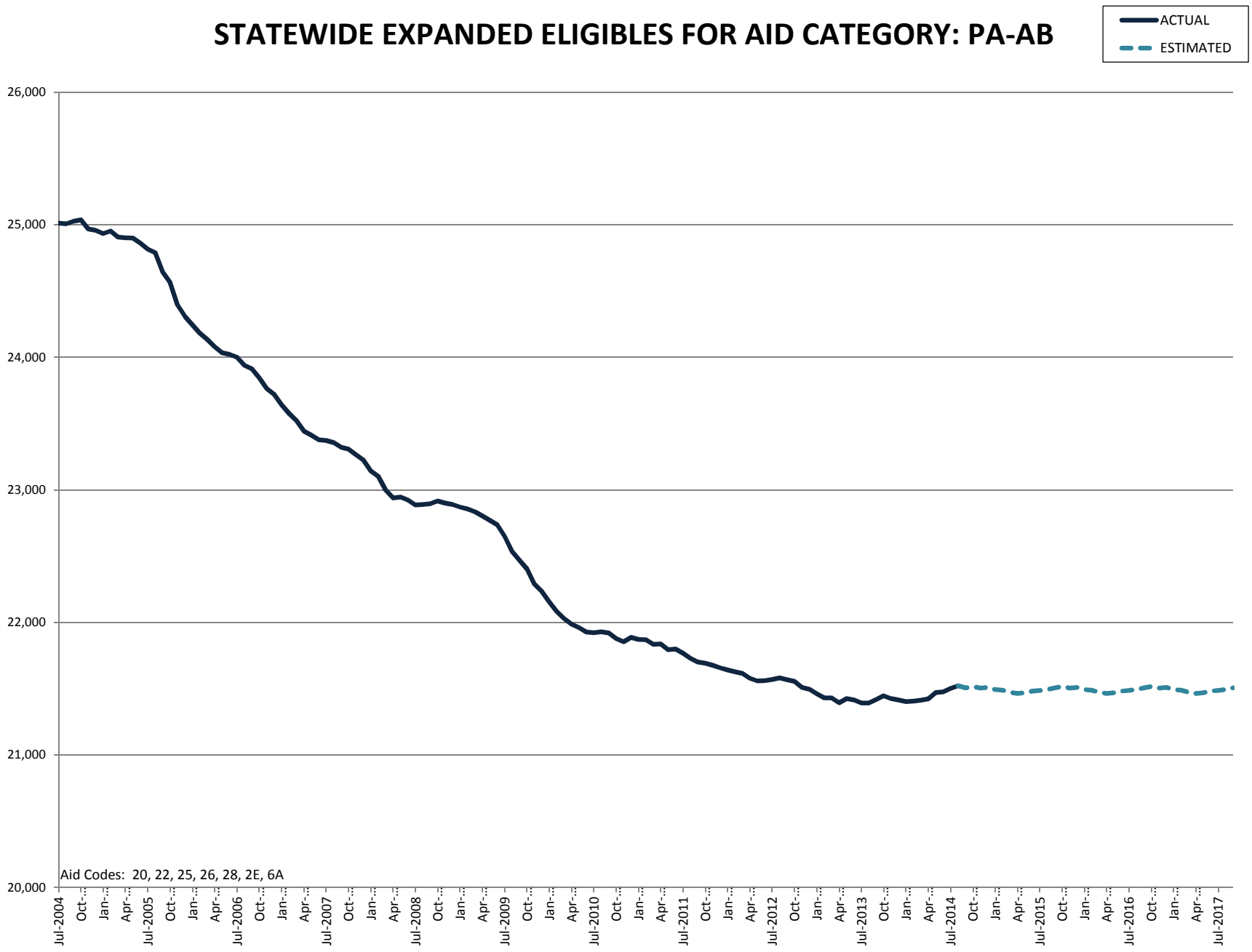
The All Aids Eligibles graph represents only the nineteen aid categories and does not incorporate future changes in policy.

For estimating purposes, the Medi-Cal eligibles are divided into nineteen categories. Of these nineteen, most can be categorized as: Aged & Disabled (OAS, AB, ATD) or the Children & Families (AFDC & POV).

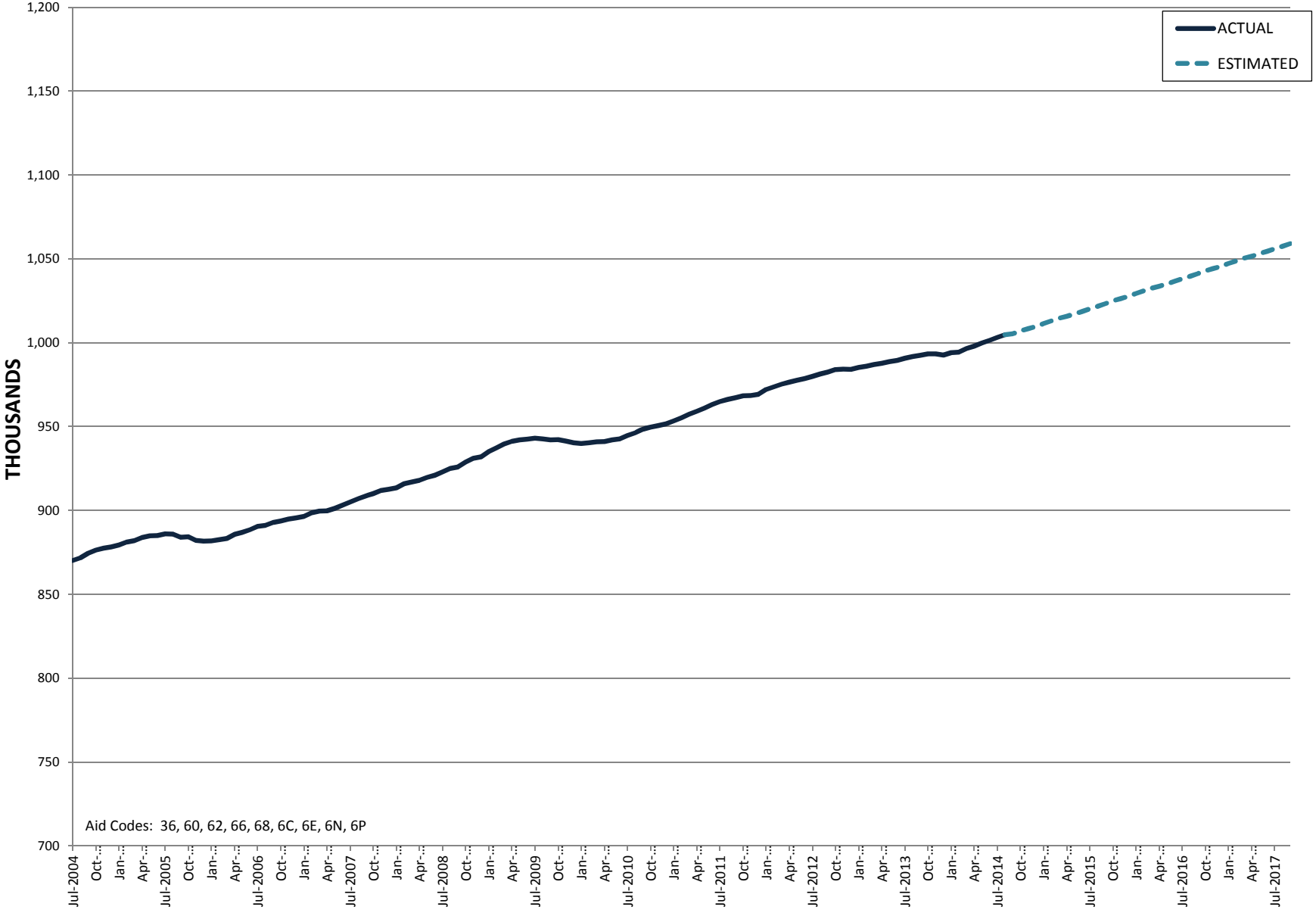
The Aged & Disabled populations tend to have a historically steady upward growth. The Children & Families populations tend to fluctuate with the unemployment level.

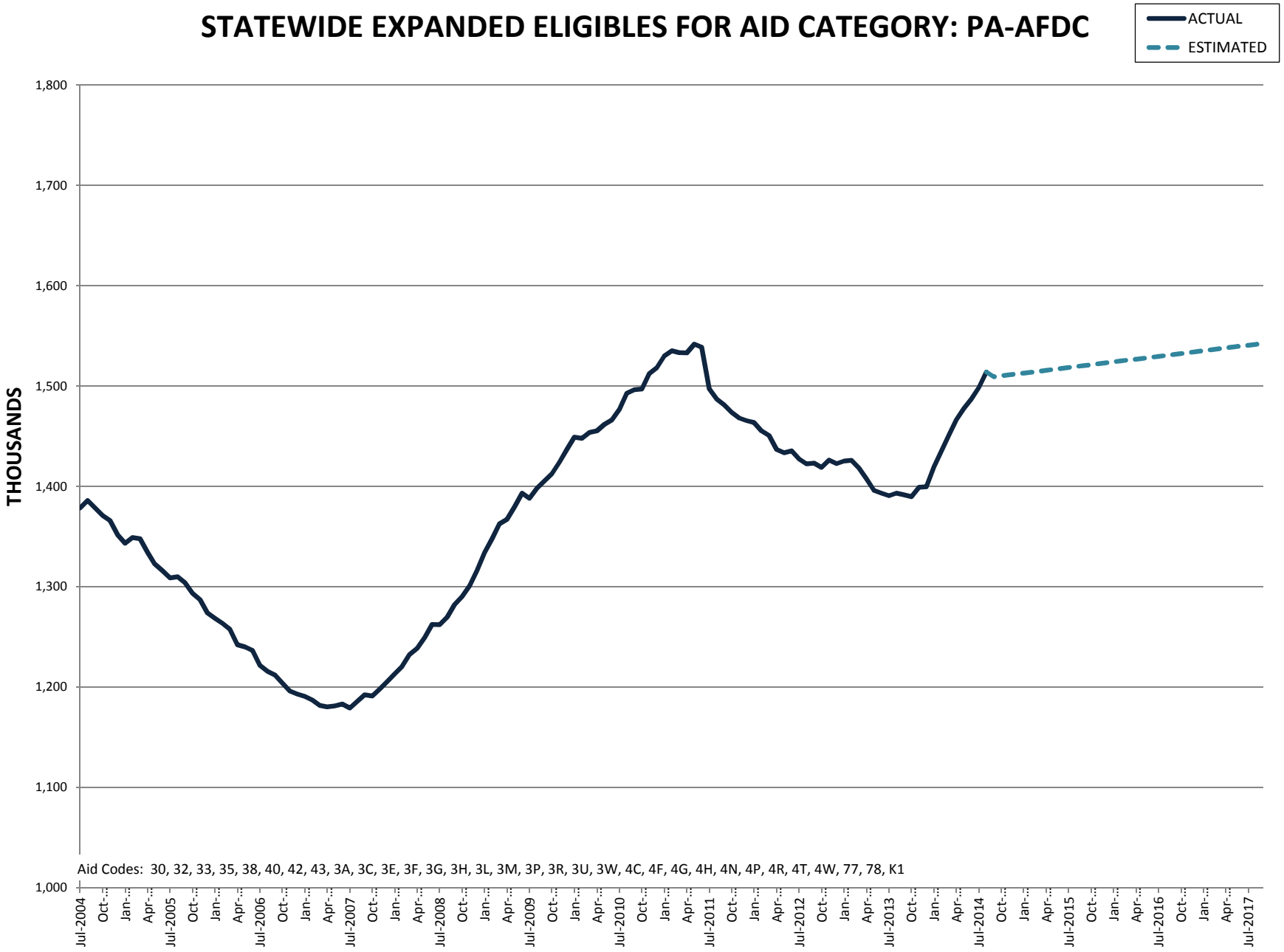
The increase beginning in 2007 is attributed to the Great Recession. Beginning in January 2013, Medi-Cal expanded to include the formerly Health Families program. In January 2014, Medi-Cal expanded due to ACA. The increase due to ACA incorporated into this graph do not include the newly eligible childless adult category. After the steep increase expected with ACA, Medi-Cal is expected to continue with positive growth of 1.2% between FY 2014-15 and 2014-15.

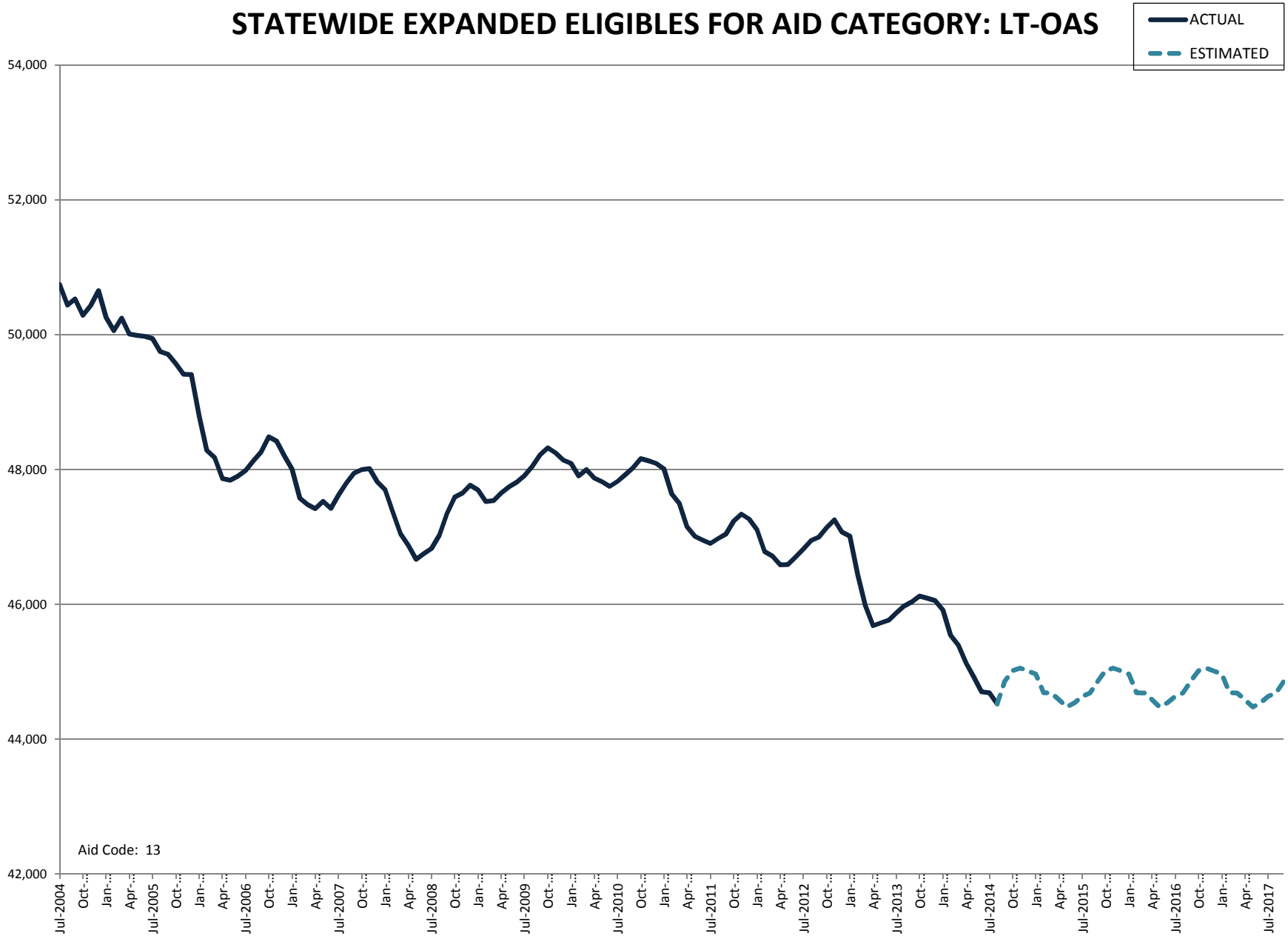

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: PA-OAS
ACTUAL
ESTIMATED
THOUSANDS
500
475
450
425
400
375
350
Aid Codes: 10, 12, 15, 16, 18, 1E
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

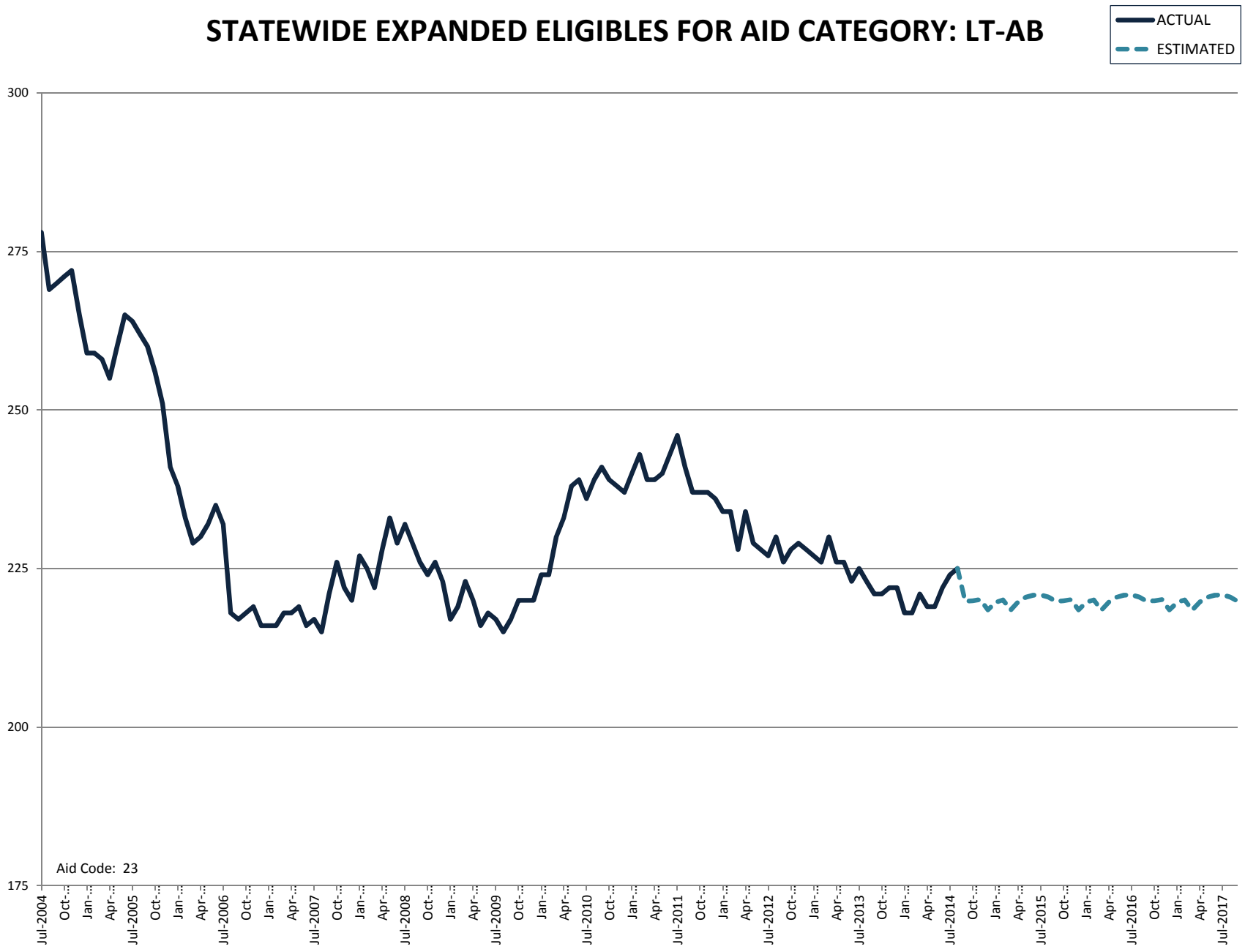

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: PA-AB
ACTUAL
ESTIMATED
26,000
25,000
24,000
23,000
22,000
21,000
20,000
Aid Codes: 20, 22, 25, 26, 28, 2E, 6A
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

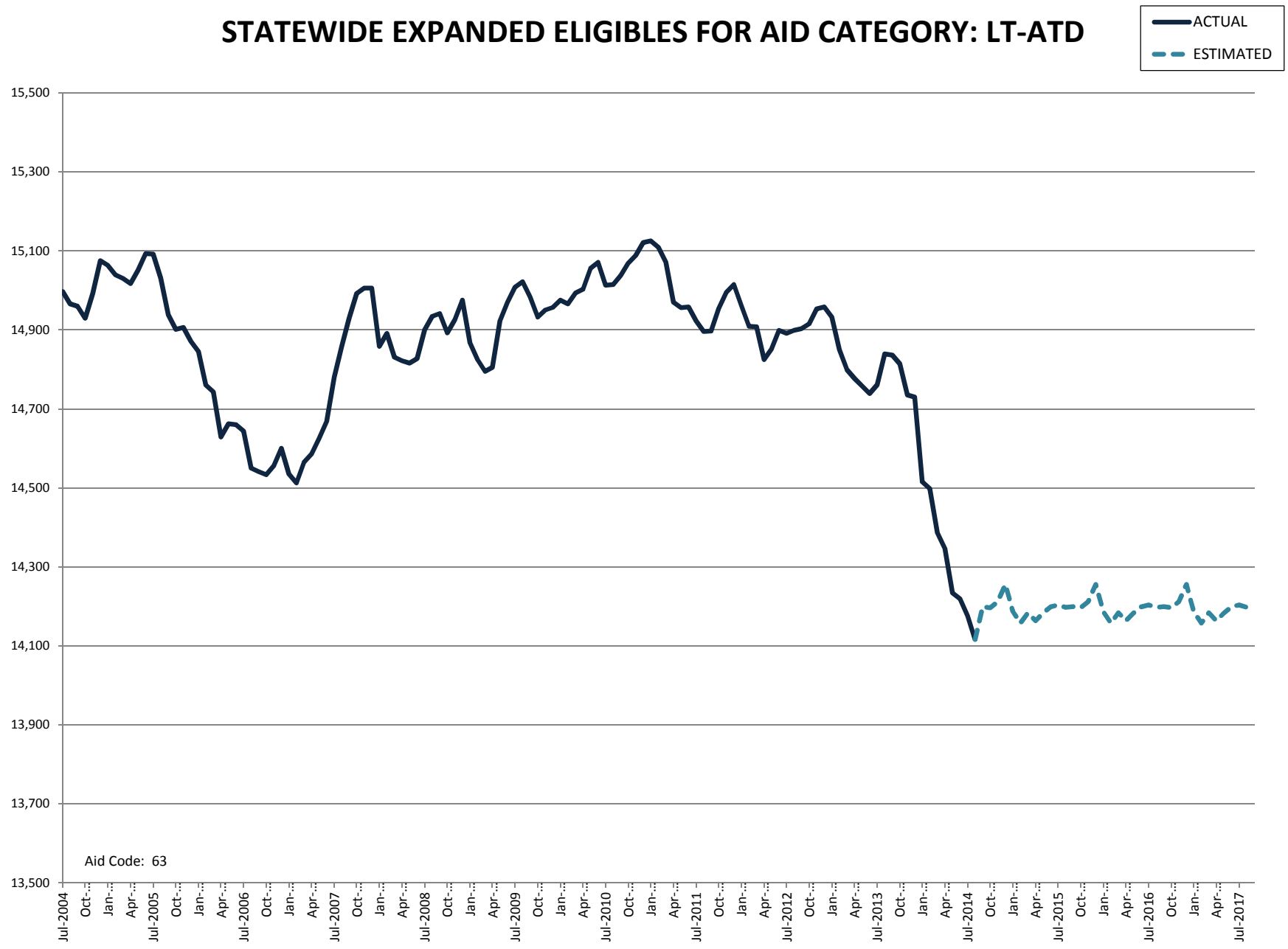
STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: PA-ATD

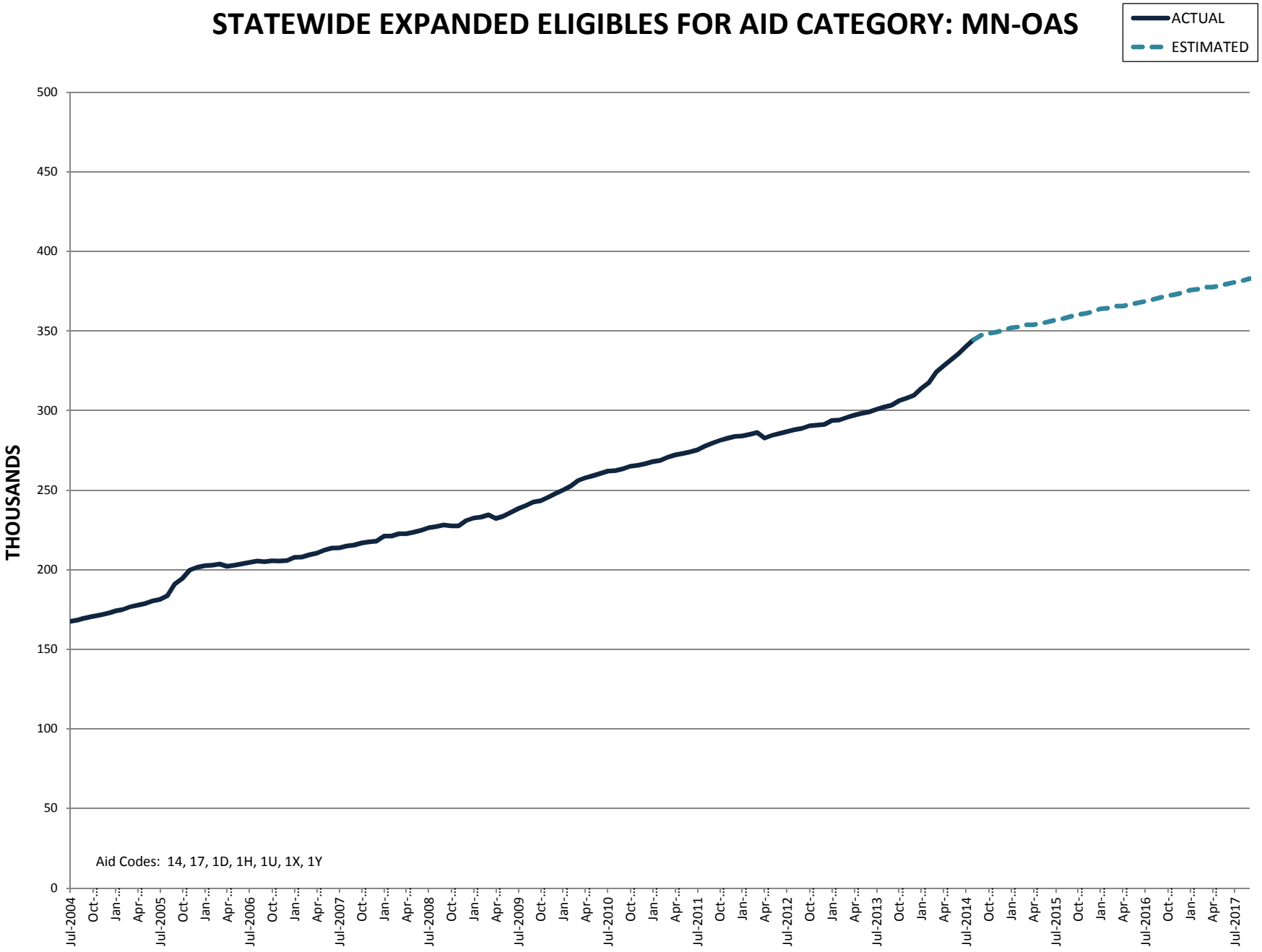


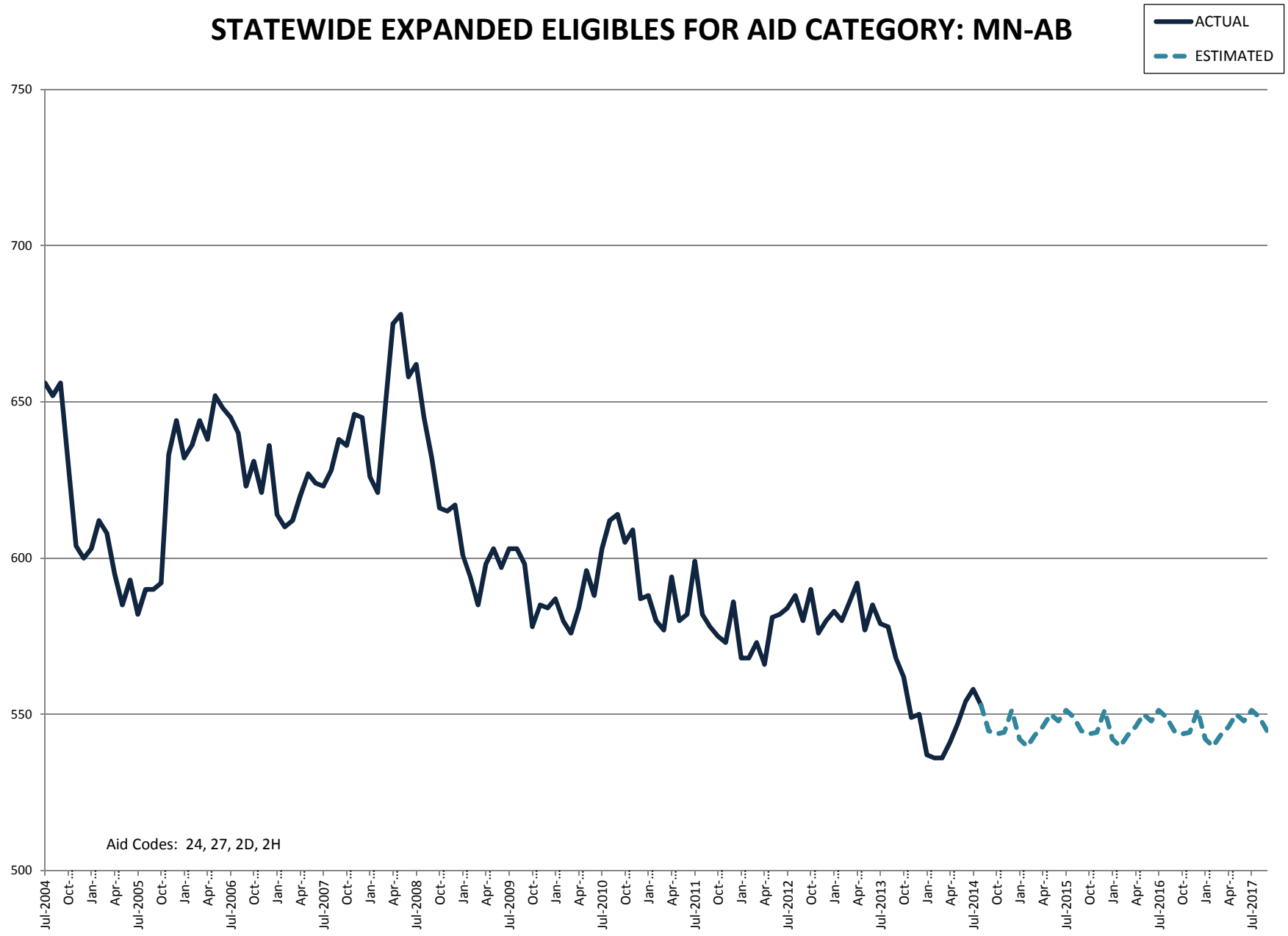

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: PA-AFDC
ACTUAL
ESTIMATED
THOUSANDS
1,800
1,700
1,600
1,500
1,400
1,300
1,200
1,100
1,000
Aid Codes: 30, 32, 33, 35, 38, 40, 42, 43, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 3W, 4C, 4F, 4G, 4H, 4N, 4P, 4R, 4T, 4W, 77, 78, K1
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

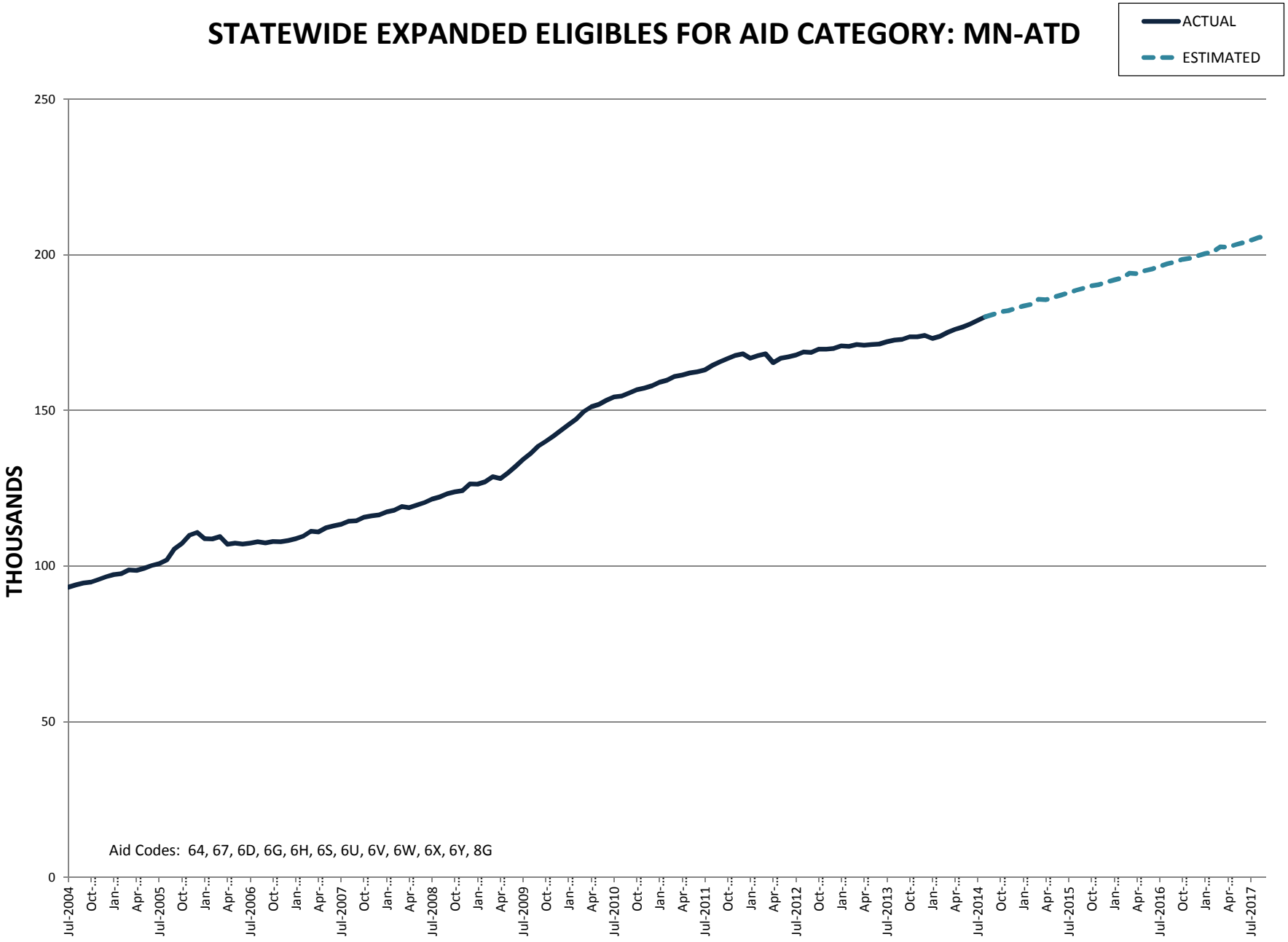

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: LT-OAS
ACTUAL
ESTIMATED
54,000
52,000
50,000
48,000
46,000
44,000
42,000
Aid Code: 13
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

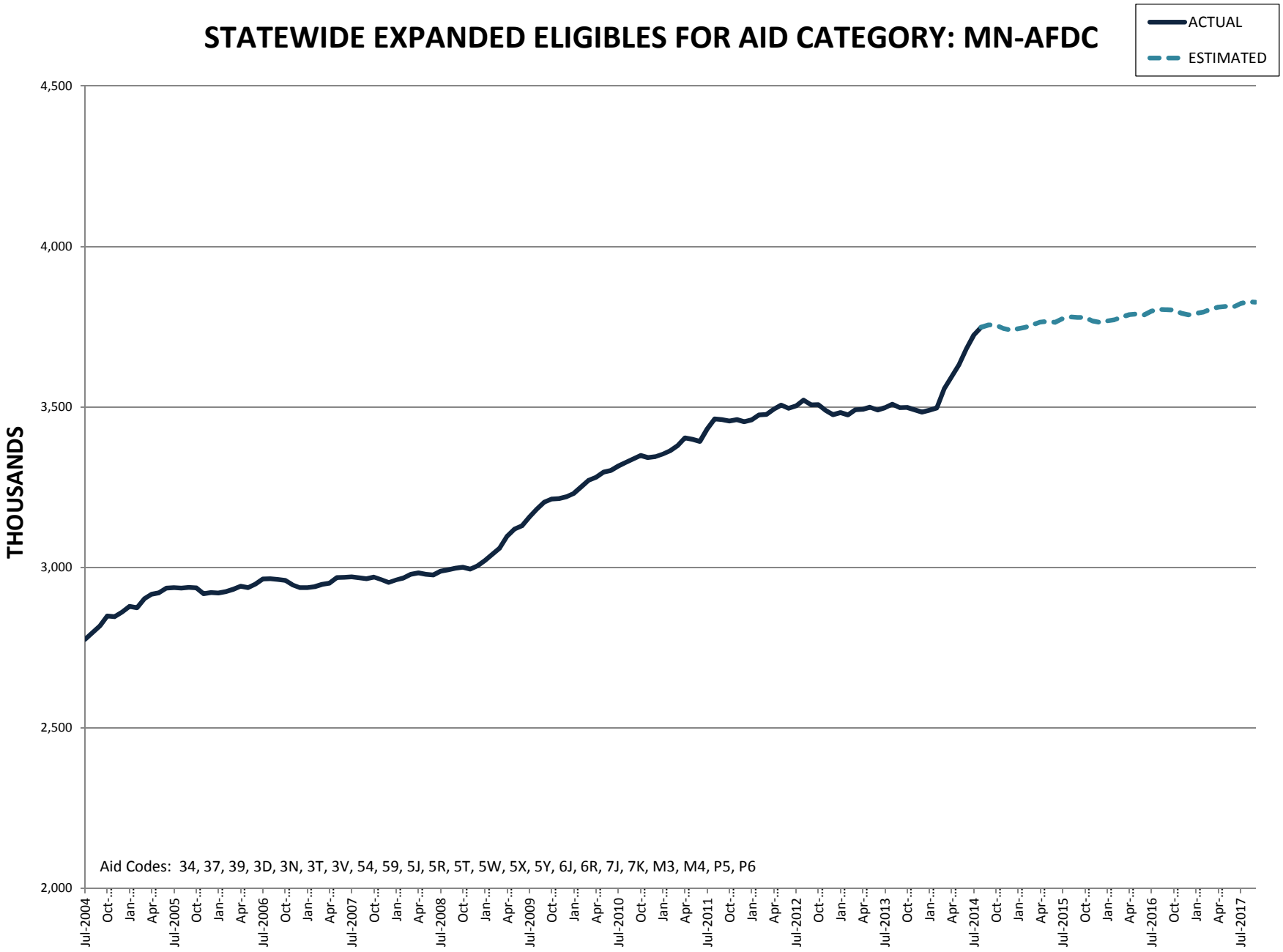

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: LT-AB
ACTUAL
ESTIMATED
300
275
250
225
200
175
Aid Code: 23
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

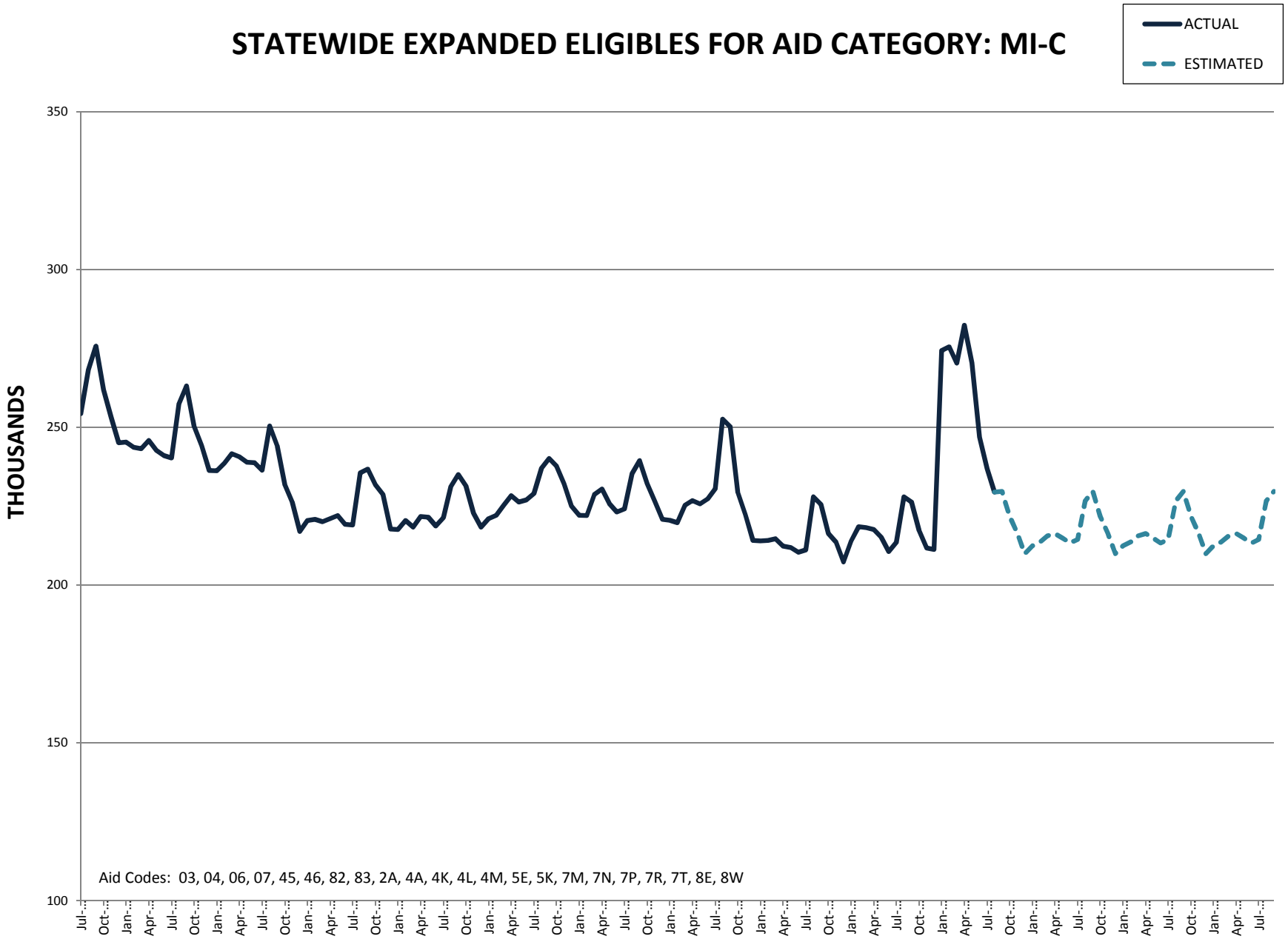

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: LT-ATD
ACTUAL
ESTIMATED
15,500
15,300
15,100
14,900
14,700
14,500
14,300
14,100
13,900
13,700
13,500
Aid Code: 63
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

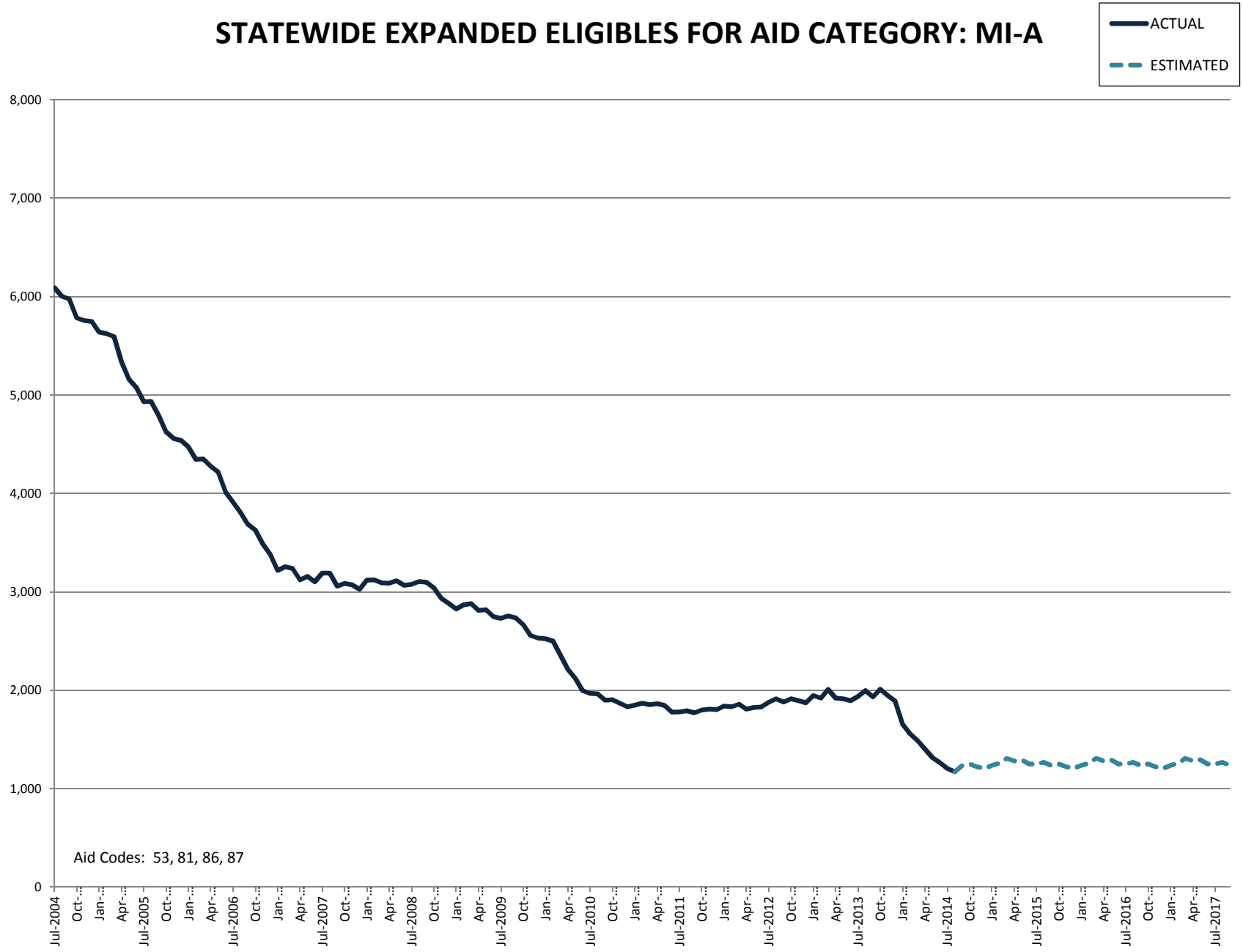

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MN-OAS
ACTUAL
ESTIMATED
THOUSANDS
500
450
400
350
300
250
200
150
100
50
0
Aid Codes: 14, 17, 1D, 1H, 1U, 1X, 1Y
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

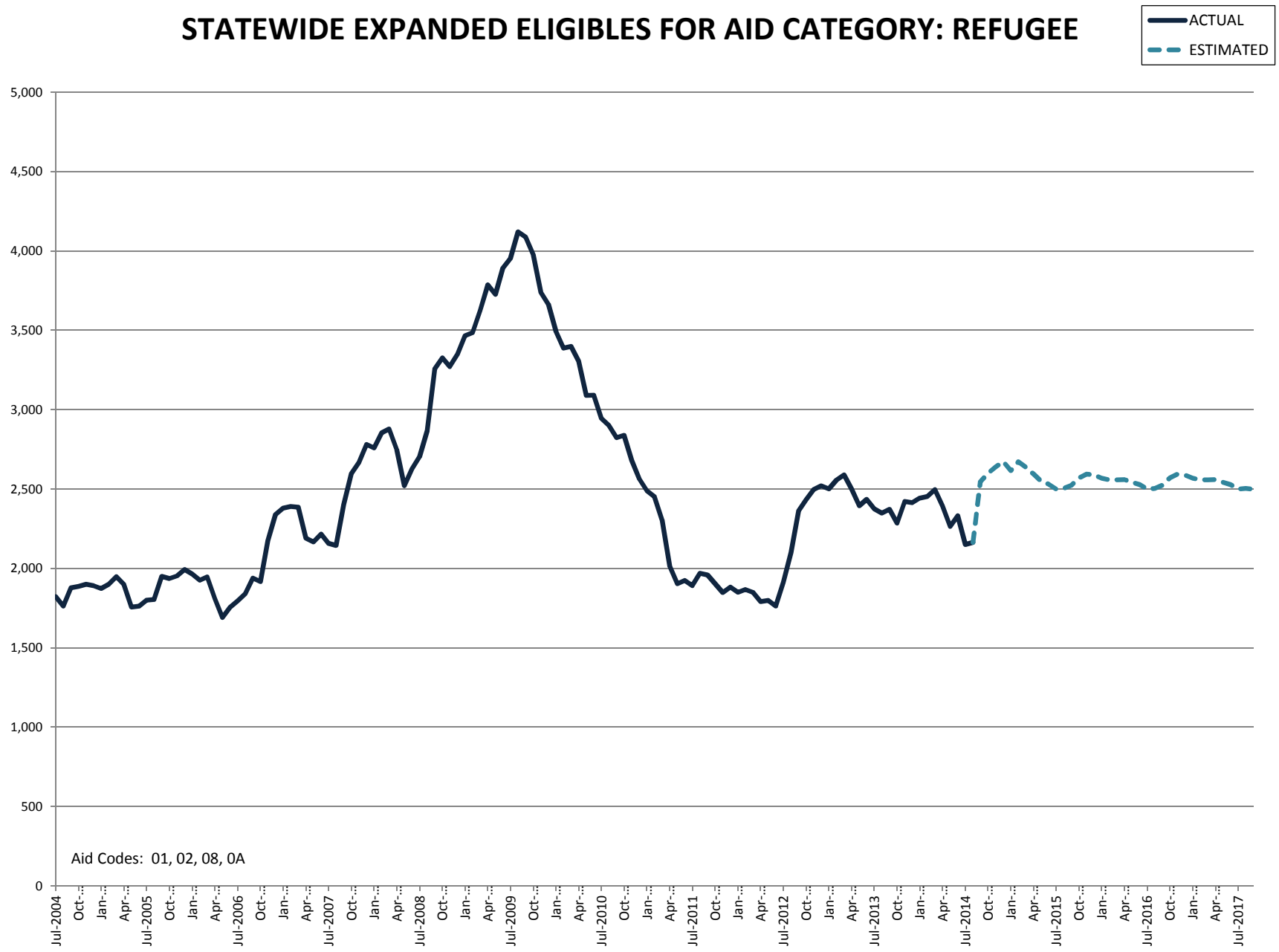

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MN-AB
ACTUAL
ESTIMATED
750
700
650
600
550
500
Aid Codes: 24, 27, 2D, 2H
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

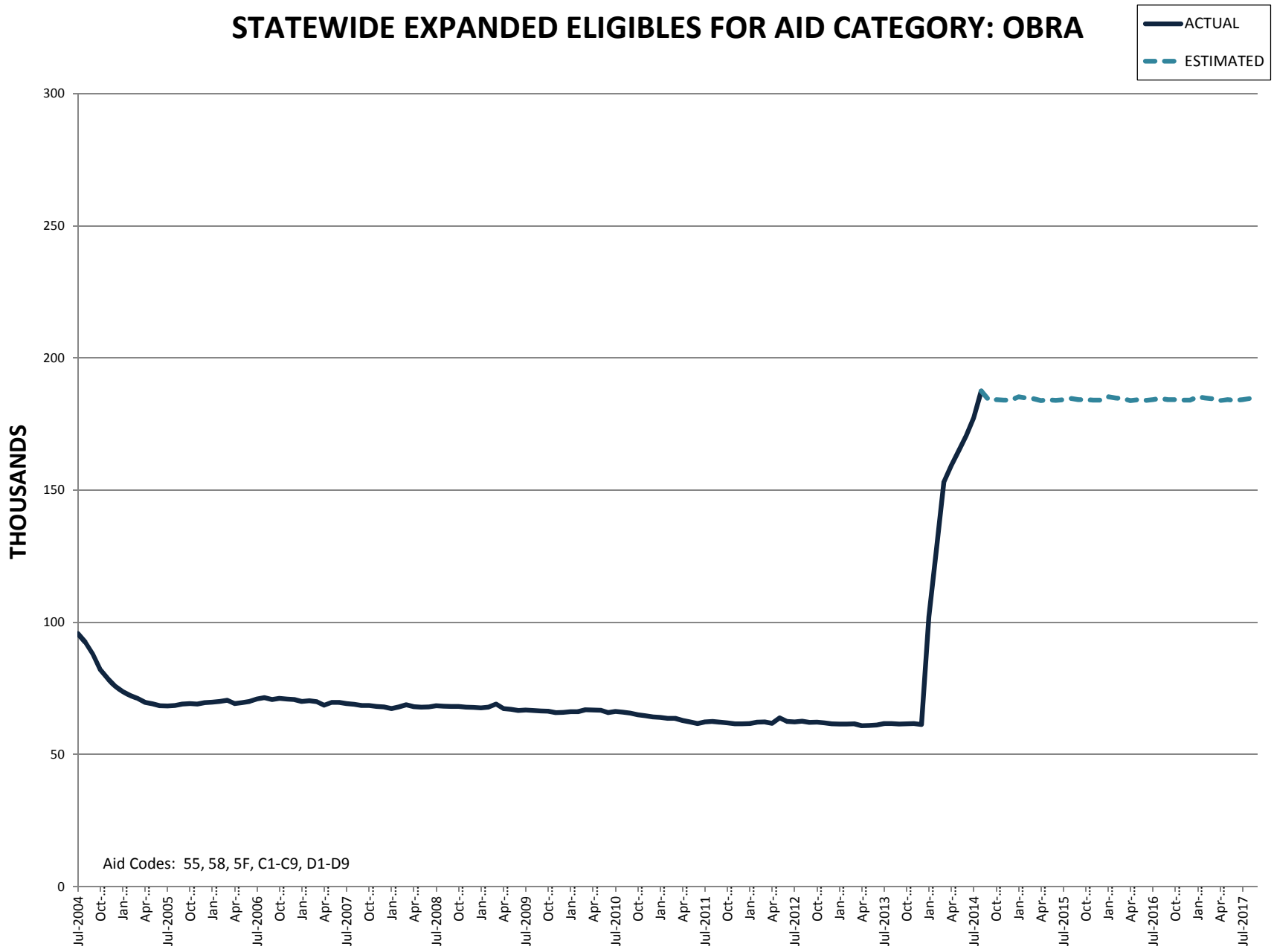

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MN-ATD
ACTUAL
ESTIMATED
THOUSANDS
250
200
150
100
50
0
Aid Codes: 64, 67, 6D, 6G, 6H, 6S, 6U, 6V, 6W, 6X, 6Y, 8G
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

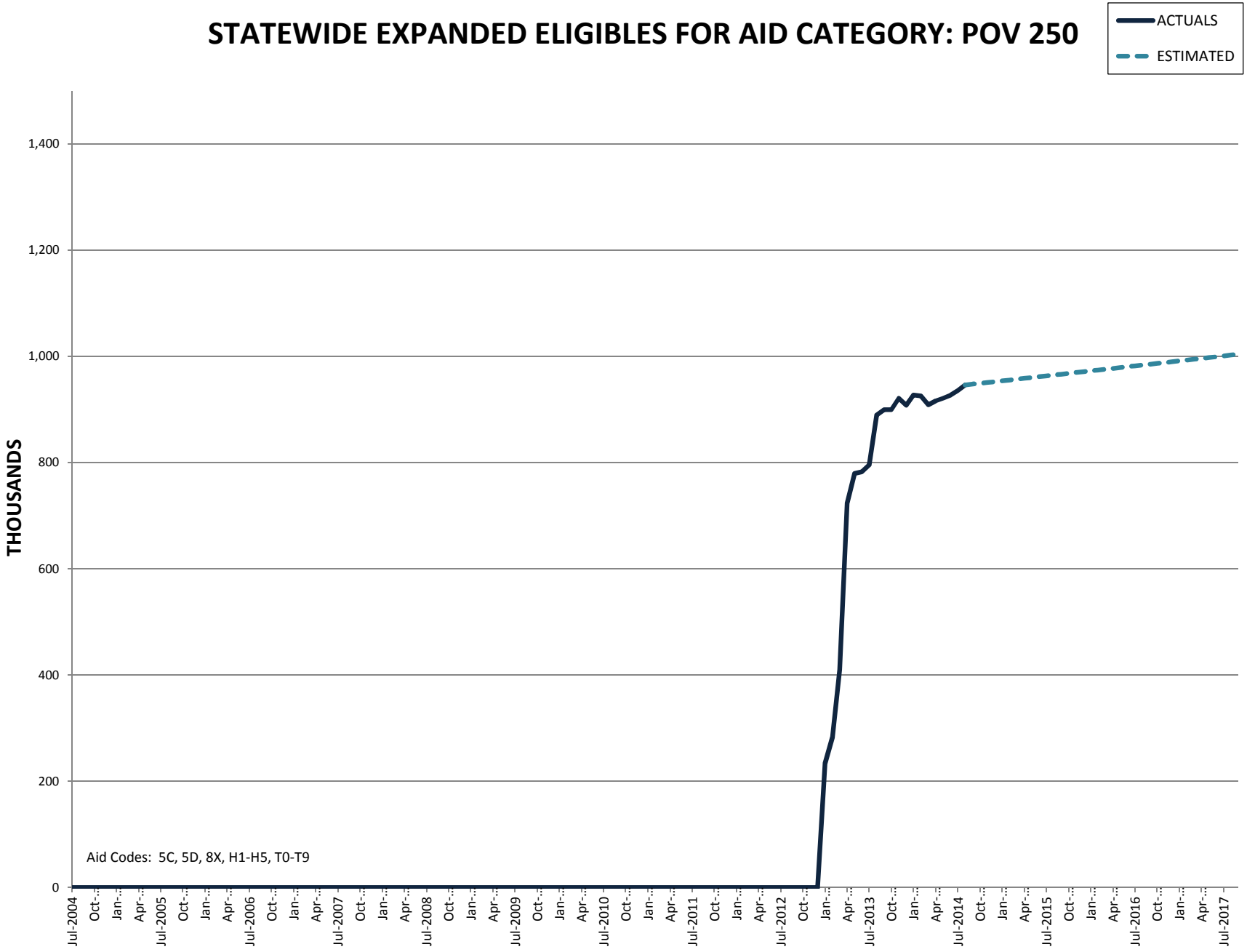

STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MN-AFDC
ACTUAL
ESTIMATED
THOUSANDS
4,500
4,000
3,500
3,000
2,500
2,000
Aid Codes: 34, 37, 39, 3D, 3N, 3T, 3V, 54, 59, 5J, 5R, 5T, 5W, 5X, 5Y, 6J, 6R, 7J, 7K, M3, M4, P5, P6
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MI-C
ACTUAL
ESTIMATED
THOUSANDS
350
300
250
200
150
100
Aid Codes: 03, 04, 06, 07, 45, 46, 82, 83, 2A, 4A, 4K, 4L, 4M, 5E, 5K, 7M, 7N, 7P, 7R, 7T, 8E, 8W
Jul-
Oct-
Jan-
Apr-


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: MI-A
ACTUAL
ESTIMATED
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Aid Codes: 53, 81, 86, 87
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: REFUGEE
ACTUAL
ESTIMATED
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Aid Codes: 01, 02, 08, 0A
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: OBRA
ACTUAL
ESTIMATED
THOUSANDS
300
250
200
150
100
50
0
Aid Codes: 55, 58, 5F, C1-C9, D1-D9
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: POV 250
ACTUALS
ESTIMATED
THOUSANDS
1,400
1,200
1,000
800
600
400
200
0
Aid Codes: 5C, 5D, 8X, H1-H5, T0-T9
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
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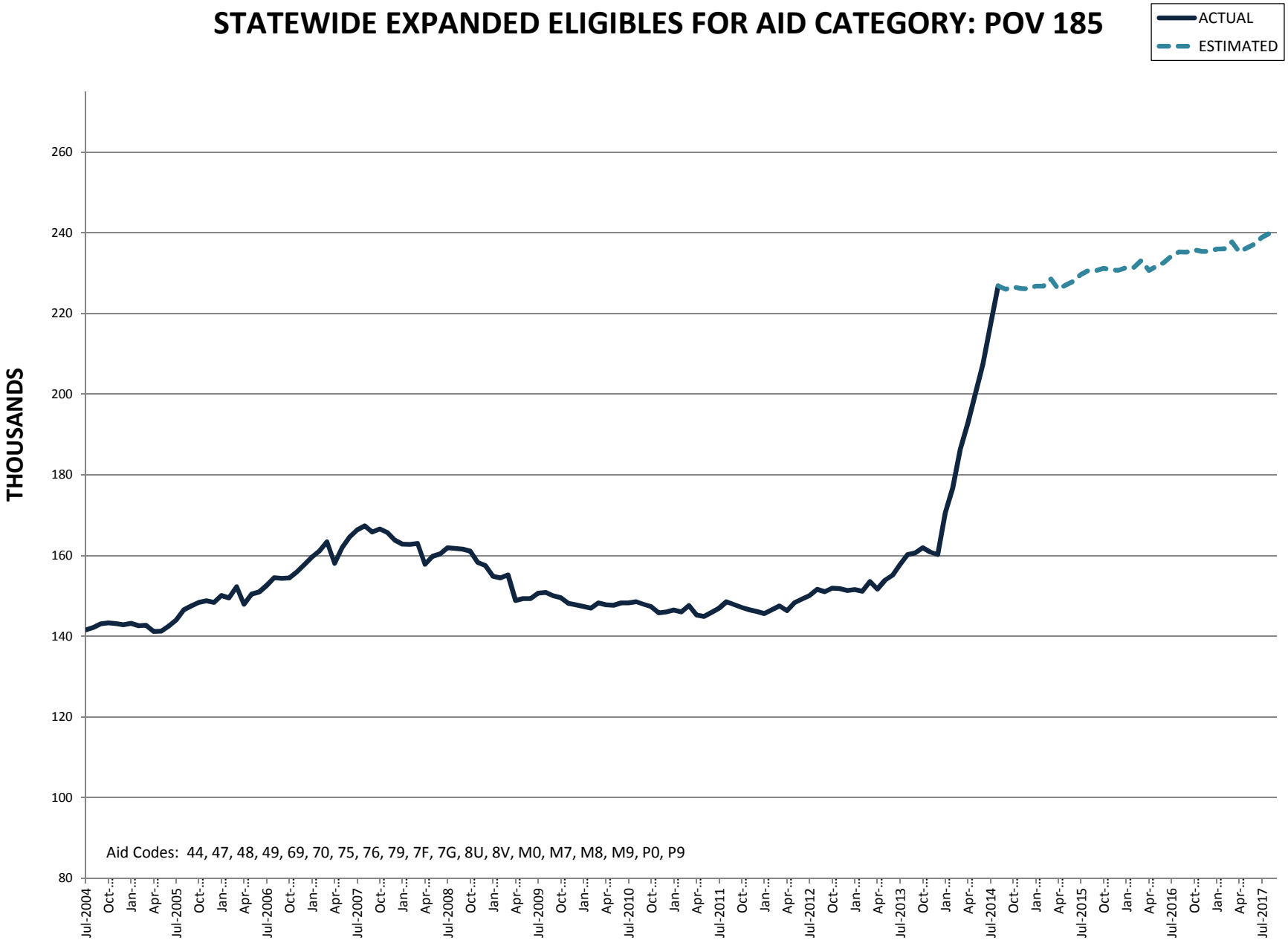
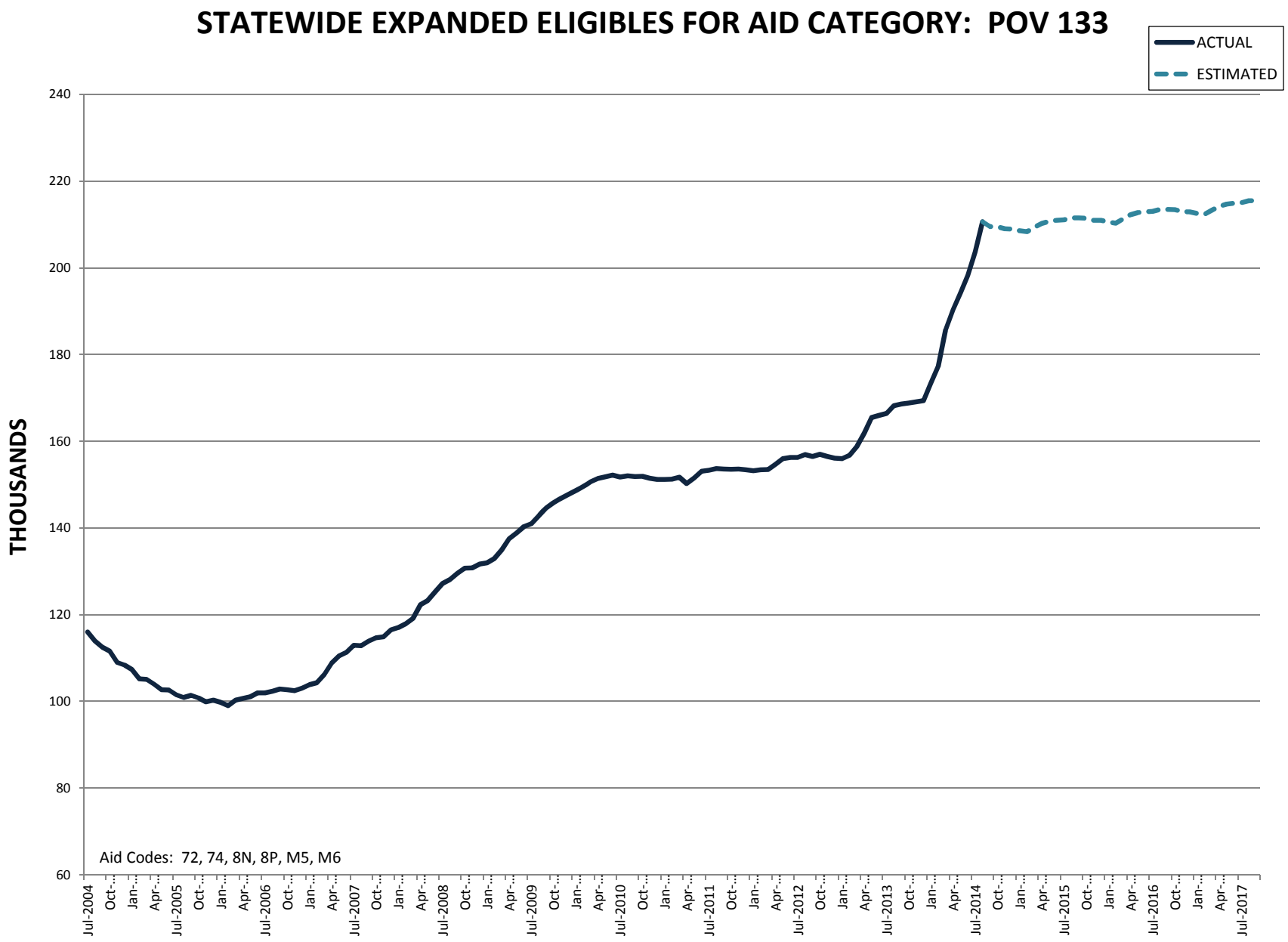
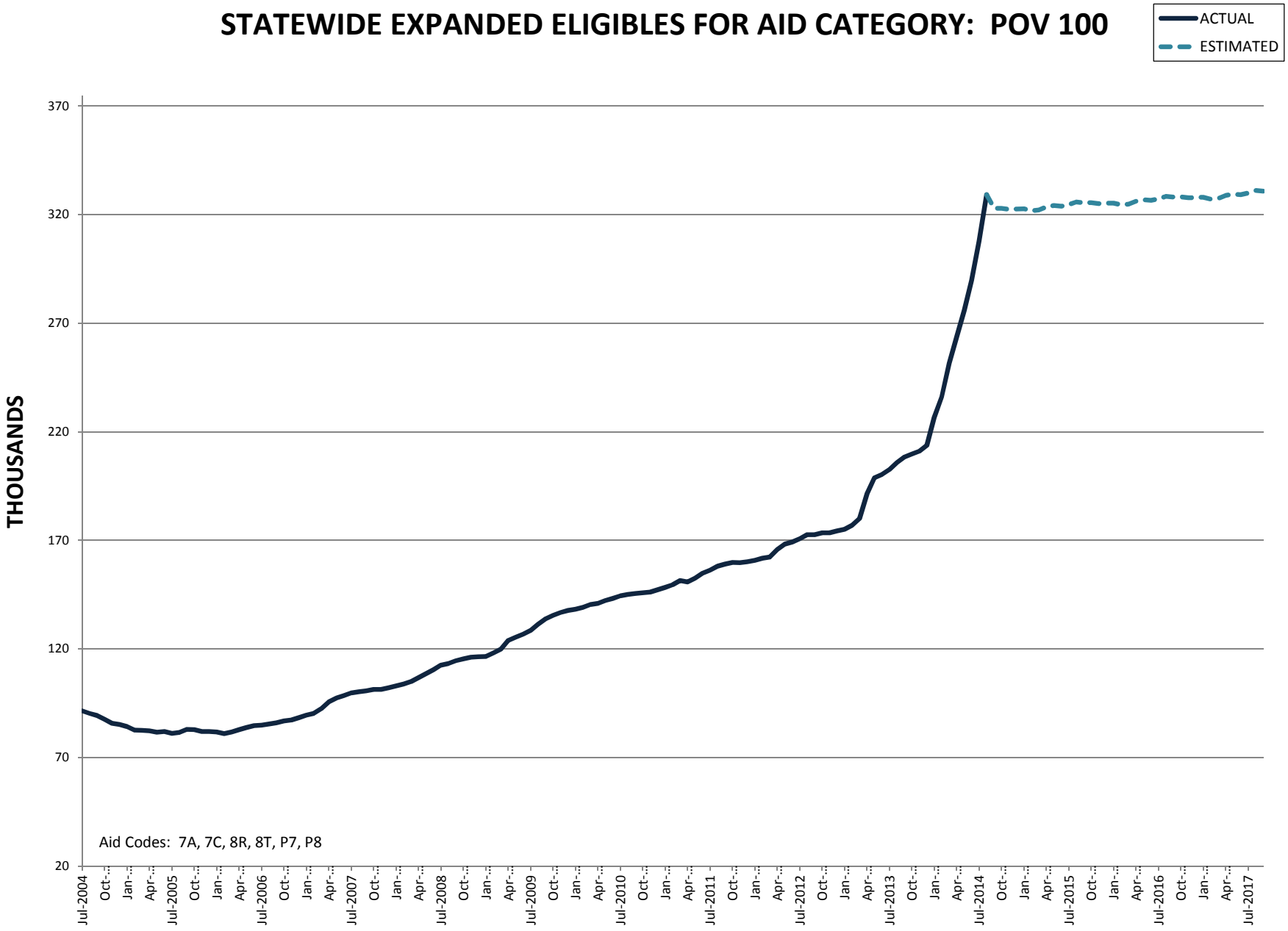
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: POV 185
ACTUAL
ESTIMATED
THOUSANDS
260
240
220
200
180
160
140
120
100
80
Aid Codes: 44, 47, 48, 49, 69, 70, 75, 76, 79, 7F, 7G, 8U, 8V, M0, M7, M8, M9, P0, P9
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: POV 133
ACTUAL
ESTIMATED
THOUSANDS
240
220
200
180
160
140
120
100
80
60
Aid Codes: 72, 74, 8N, 8P, M5, M6
Jul-2004
Oct-...
Jan-...
Apr-...
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017


STATEWIDE EXPANDED ELIGIBLES FOR AID CATEGORY: POV 100
ACTUAL
ESTIMATED
THOUSANDS
370
320
270
220
170
120
70
20
Aid Codes: 7A, 7C, 8R, 8T, P7, P8
Jul-2004
Jul-2005
Jul-2006
Jul-2007
Jul-2008
Jul-2009
Jul-2010
Jul-2011
Jul-2012
Jul-2013
Jul-2014
Jul-2015
Jul-2016
Jul-2017

Medi-Cal Fee-For-Service Base Estimate

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

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

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

FFS Base Estimate Service Categories:
Physicians
Other Medical
County Outpatient
Community Outpatient
Pharmacy
County Inpatient
Community Inpatient
Nursing Facilities
Intermediate Care Facilities-Developmentally Disabled (ICF-DD)
Medical Transportation
Other Services
Home Health

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

TOTAL FOR ALL SERVICES ACROSS ALL BASE AID CATEGORIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	1,648,340	4.78	$174.55	$834.98	$4,129,022,600
2012-13 *	2	1,636,930	4.55	$180.49	$821.10	$4,032,249,500
2012-13 *	3	1,656,950	4.49	$175.10	$785.86	$3,906,398,000
2012-13 *	4	1,521,830	4.24	$171.26	$726.43	$3,316,496,900
2012-13 *	TOTAL	1,616,010	4.52	$175.48	$793.32	$15,384,167,000
2013-14 *	1	1,740,310	4.91	$179.67	$882.12	$4,605,491,000
2013-14 *	2	1,636,680	4.45	$174.36	$775.45	$3,807,509,300
2013-14 *	3	1,672,960	4.29	$182.17	$782.20	$3,925,748,300
2013-14 *	4	1,526,470	4.13	$176.69	$729.34	$3,339,960,900
2013-14 *	TOTAL	1,644,110	4.46	$178.32	$794.69	$15,678,709,500
2014-15 **	1	1,789,530	4.56	$190.79	$869.92	$4,670,265,700
2014-15 **	2	1,686,190	4.34	$186.36	$809.02	$4,092,449,500
2014-15 **	3	1,715,950	4.29	$187.06	$802.22	$4,129,692,900
2014-15 **	4	1,565,600	4.17	$183.07	$763.02	$3,583,758,300
2014-15 **	TOTAL	1,689,320	4.35	$187.04	$812.76	$16,476,166,400
2015-16 **	1	1,808,970	4.71	$189.24	$891.60	$4,838,643,000
2015-16 **	2	1,770,720	4.48	$189.29	$848.64	$4,508,124,400
2015-16 **	3	1,651,260	4.16	$189.78	$789.12	$3,909,115,000
2015-16 **	4	1,650,610	4.30	$185.23	$796.08	$3,942,033,400
2015-16 **	TOTAL	1,720,390	4.42	$188.44	$833.04	$17,197,915,700

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

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

PHYSICIANS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	459,480	2.20	$78.04	$172.04	$237,154,500
2012-13 *	2	425,170	2.15	$77.16	$166.25	$212,060,100
2012-13 *	3	491,900	2.09	$74.59	$155.82	$229,941,200
2012-13 *	4	423,980	2.07	$72.41	$149.76	$190,490,400
2012-13 *	TOTAL	450,130	2.13	$75.62	$161.00	$869,646,300
2013-14 *	1	481,170	2.25	$75.84	$170.32	$245,851,800
2013-14 *	2	421,280	2.16	$75.45	$162.69	$205,616,100
2013-14 *	3	457,620	2.07	$69.97	$144.88	$198,894,000
2013-14 *	4	384,540	2.04	$78.66	$160.80	$185,499,300
2013-14 *	TOTAL	436,150	2.13	$74.84	$159.70	$835,861,200
2014-15 **	1	456,710	2.24	$83.06	$186.04	$254,903,300
2014-15 **	2	411,490	2.16	$75.46	$162.96	$201,172,100
2014-15 **	3	471,420	2.08	$72.61	$151.07	$213,657,600
2014-15 **	4	403,580	2.07	$72.67	$150.11	$181,740,700
2014-15 **	TOTAL	435,800	2.14	$76.17	$162.82	$851,473,800
2015-16 **	1	466,590	2.28	$75.75	$173.02	$242,186,900
2015-16 **	2	435,960	2.20	$75.86	$166.84	$218,201,400
2015-16 **	3	453,010	2.03	$72.62	$147.77	$200,817,100
2015-16 **	4	427,930	2.09	$72.91	$152.51	$195,794,200
2015-16 **	TOTAL	445,870	2.15	$74.37	$160.17	$856,999,700

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

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

OTHER MEDICAL

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	708,590	1.68	$129.05	$216.89	$461,047,500
2012-13 *	2	705,620	1.63	$132.09	$215.83	$456,868,200
2012-13 *	3	727,760	1.63	$132.48	$215.85	$471,257,200
2012-13 *	4	650,080	1.59	$141.50	$225.55	$439,887,800
2012-13 *	TOTAL	698,010	1.64	$133.54	$218.37	$1,829,060,700
2013-14 *	1	803,930	1.68	$156.64	$263.09	$634,517,000
2013-14 *	2	741,000	1.62	$136.83	$222.04	$493,594,800
2013-14 *	3	751,760	1.60	$140.55	$224.31	$505,886,100
2013-14 *	4	693,510	1.57	$138.44	$216.81	$451,083,900
2013-14 *	TOTAL	747,550	1.62	$143.64	$232.44	$2,085,081,800
2014-15 **	1	877,250	1.65	$143.05	$236.31	$621,906,200
2014-15 **	2	814,640	1.59	$141.63	$225.58	$551,296,300
2014-15 **	3	816,740	1.59	$140.78	$223.86	$548,501,400
2014-15 **	4	731,020	1.56	$140.61	$220.04	$482,555,400
2014-15 **	TOTAL	809,910	1.60	$141.59	$226.80	$2,204,259,400
2015-16 **	1	891,730	1.69	$141.08	$237.85	$636,302,000
2015-16 **	2	867,020	1.62	$141.54	$229.25	$596,279,800
2015-16 **	3	777,200	1.56	$140.75	$219.36	$511,467,600
2015-16 **	4	782,840	1.58	$140.66	$222.62	$522,835,300
2015-16 **	TOTAL	829,700	1.61	$141.03	$227.68	$2,266,884,700

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

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

COUNTY OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	23,850	1.69	$118.01	$199.54	$14,279,200
2012-13 *	2	25,090	1.86	$93.61	$174.16	$13,109,800
2012-13 *	3	20,560	1.63	$123.12	$200.90	$12,392,300
2012-13 *	4	21,130	1.70	$110.05	$186.99	$11,852,200
2012-13 *	TOTAL	22,660	1.73	$110.00	$189.90	$51,633,400
2013-14 *	1	24,640	1.71	$113.68	$194.55	$14,382,400
2013-14 *	2	23,710	1.65	$95.38	$157.83	$11,223,700
2013-14 *	3	21,810	1.59	$115.87	$184.21	$12,050,600
2013-14 *	4	22,410	1.63	$95.88	$155.91	$10,481,300
2013-14 *	TOTAL	23,140	1.65	$105.22	$173.35	$48,138,000
2014-15 **	1	28,670	1.68	$101.80	$170.56	$14,671,400
2014-15 **	2	26,070	1.61	$105.31	$169.22	$13,235,600
2014-15 **	3	23,690	1.55	$116.40	$180.65	$12,838,200
2014-15 **	4	22,450	1.58	$104.77	$165.62	$11,155,900
2014-15 **	TOTAL	25,220	1.61	$106.67	$171.48	$51,901,100
2015-16 **	1	27,690	1.67	$113.43	$189.30	$15,727,200
2015-16 **	2	27,820	1.62	$106.04	$172.09	$14,360,700
2015-16 **	3	22,470	1.53	$117.12	$178.97	$12,065,900
2015-16 **	4	23,990	1.59	$104.02	$165.46	$11,908,100
2015-16 **	TOTAL	25,490	1.61	$109.98	$176.72	$54,061,900

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

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

COMMUNITY OUTPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	196,180	1.56	$118.24	$184.48	$108,575,600
2012-13 *	2	242,000	1.73	$92.69	$160.19	$116,301,000
2012-13 *	3	191,400	1.63	$105.77	$172.76	$99,196,400
2012-13 *	4	184,510	1.66	$95.05	$157.97	$87,441,900
2012-13 *	TOTAL	203,520	1.65	$102.09	$168.50	$411,514,900
2013-14 *	1	240,000	1.60	$116.64	$187.01	$134,644,700
2013-14 *	2	228,030	1.58	$95.86	$151.13	$103,389,700
2013-14 *	3	203,490	1.55	$102.64	$158.64	$96,849,600
2013-14 *	4	189,460	1.54	$99.39	$153.16	$87,053,300
2013-14 *	TOTAL	215,240	1.57	$104.12	$163.36	$421,937,300
2014-15 **	1	241,470	1.62	$98.42	$159.06	$115,225,600
2014-15 **	2	223,520	1.58	$100.23	$158.16	$106,052,600
2014-15 **	3	213,440	1.55	$105.21	$163.00	$104,368,000
2014-15 **	4	199,280	1.55	$100.37	$155.71	$93,091,000
2014-15 **	TOTAL	219,430	1.58	$100.94	$159.03	$418,737,100
2015-16 **	1	239,110	1.63	$108.00	$176.04	$126,276,700
2015-16 **	2	238,780	1.60	$100.21	$160.81	$115,197,700
2015-16 **	3	200,930	1.53	$105.62	$161.71	$97,479,800
2015-16 **	4	214,920	1.57	$99.83	$157.21	$101,362,900
2015-16 **	TOTAL	223,440	1.59	$103.43	$164.22	$440,317,100

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

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

PHARMACY

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	660,670	3.10	$103.60	$321.48	$637,174,200
2012-13 *	2	645,370	2.96	$100.85	$298.49	$577,911,000
2012-13 *	3	628,030	2.97	$106.82	$317.53	$598,243,400
2012-13 *	4	529,370	2.88	$111.46	$321.19	$510,076,300
2012-13 *	TOTAL	615,860	2.98	$105.34	$314.39	$2,323,405,000
2013-14 *	1	621,950	3.22	$117.10	$377.62	$704,586,200
2013-14 *	2	543,530	2.99	$121.62	$363.56	$592,812,000
2013-14 *	3	549,590	2.91	$131.07	$381.12	$628,381,300
2013-14 *	4	474,850	2.94	$128.88	$378.86	$539,706,700
2013-14 *	TOTAL	547,480	3.02	$124.06	$375.28	$2,465,486,100
2014-15 **	1	545,840	3.23	$142.31	$459.54	$752,502,300
2014-15 **	2	523,790	2.99	$141.48	$423.63	$665,667,500
2014-15 **	3	519,770	2.94	$144.24	$424.76	$662,325,500
2014-15 **	4	449,670	2.89	$148.98	$430.56	$580,835,300
2014-15 **	TOTAL	509,770	3.02	$143.98	$435.06	$2,661,330,600
2015-16 **	1	556,780	3.28	$152.28	$498.95	$833,410,700
2015-16 **	2	550,390	3.06	$152.14	$465.82	$769,155,700
2015-16 **	3	493,240	2.84	$154.84	$440.20	$651,361,100
2015-16 **	4	476,440	2.93	$159.49	$467.71	$668,505,500
2015-16 **	TOTAL	519,210	3.04	$154.41	$469.05	$2,922,432,900

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

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

COUNTY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	6,380	6.00	$1,565.09	$9,389.41	$179,816,700
2012-13 *	2	6,830	5.89	$1,562.82	$9,200.97	$188,564,700
2012-13 *	3	5,760	5.61	$1,563.89	$8,777.52	$151,570,200
2012-13 *	4	4,790	5.42	$1,605.73	$8,697.94	$124,972,100
2012-13 *	TOTAL	5,940	5.76	$1,571.85	$9,047.62	$644,923,700
2013-14 *	1	4,740	5.36	$1,640.26	$8,787.36	$124,982,700
2013-14 *	2	4,530	5.31	$1,620.57	$8,602.67	$117,013,600
2013-14 *	3	4,640	5.77	$1,666.32	$9,622.42	$133,867,100
2013-14 *	4	4,090	4.96	$1,615.38	$8,011.89	$98,386,100
2013-14 *	TOTAL	4,500	5.36	$1,637.35	$8,779.63	$474,249,400
2014-15 **	1	5,520	5.54	$1,690.46	$9,358.74	$154,981,500
2014-15 **	2	5,150	5.22	$1,684.92	$8,801.00	$136,035,500
2014-15 **	3	5,430	5.34	$1,690.98	$9,029.08	$147,131,500
2014-15 **	4	4,830	5.18	$1,683.30	$8,712.37	$126,209,100
2014-15 **	TOTAL	5,230	5.33	$1,687.65	$8,986.81	$564,357,600
2015-16 **	1	5,750	5.43	$1,704.09	$9,249.27	$159,619,400
2015-16 **	2	5,730	5.20	$1,688.32	$8,781.35	$151,061,000
2015-16 **	3	5,200	5.28	$1,694.28	$8,946.86	$139,620,400
2015-16 **	4	5,190	5.18	$1,683.42	$8,723.84	$135,840,400
2015-16 **	TOTAL	5,470	5.28	$1,692.86	$8,930.09	$586,141,200

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

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

COMMUNITY INPATIENT

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	45,840	3.40	$2,019.98	$6,865.53	$944,209,000
2012-13 *	2	43,580	3.42	$2,026.58	$6,929.72	$905,894,900
2012-13 *	3	44,360	3.43	$2,036.75	$6,981.65	$929,103,800
2012-13 *	4	37,680	3.51	$2,023.41	$7,111.18	$803,918,300
2012-13 *	TOTAL	42,870	3.44	$2,026.75	$6,965.87	$3,583,126,100
2013-14 *	1	47,080	3.73	$1,937.94	$7,235.75	$1,021,912,800
2013-14 *	2	42,510	3.62	$1,847.91	$6,691.33	$853,378,200
2013-14 *	3	43,630	3.90	$1,904.04	$7,431.93	$972,831,800
2013-14 *	4	36,900	3.68	$1,930.12	$7,107.18	$786,679,700
2013-14 *	TOTAL	42,530	3.74	$1,905.39	$7,122.13	$3,634,802,600
2014-15 **	1	44,830	4.07	$1,916.47	$7,802.40	$1,049,234,900
2014-15 **	2	43,210	3.95	$1,909.08	$7,549.98	$978,708,000
2014-15 **	3	44,790	3.96	$1,925.44	$7,621.00	$1,023,977,100
2014-15 **	4	38,730	3.88	$1,927.02	$7,473.62	$868,367,200
2014-15 **	TOTAL	42,890	3.97	$1,919.28	$7,617.24	$3,920,287,200
2015-16 **	1	47,800	4.05	$1,953.82	$7,921.99	$1,135,995,900
2015-16 **	2	46,440	3.99	$1,943.37	$7,745.85	$1,079,147,000
2015-16 **	3	42,420	3.92	$1,954.84	$7,670.56	$976,141,500
2015-16 **	4	41,680	3.89	$1,964.87	$7,649.08	$956,470,900
2015-16 **	TOTAL	44,580	3.97	$1,953.86	$7,752.53	$4,147,755,300

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

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

NURSING FACILITIES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	63,170	32.72	$177.16	$5,795.99	$1,098,473,900
2012-13 *	2	62,490	30.98	$202.09	$6,260.26	$1,173,623,400
2012-13 *	3	62,110	31.62	$180.84	$5,717.65	$1,065,392,900
2012-13 *	4	55,030	27.33	$182.75	$4,993.96	$824,468,600
2012-13 *	TOTAL	60,700	30.77	$185.71	$5,713.66	$4,161,958,800
2013-14 *	1	64,340	36.90	$180.35	$6,654.73	$1,284,555,500
2013-14 *	2	61,930	31.49	$182.49	$5,747.29	$1,067,841,000
2013-14 *	3	60,280	31.08	$181.23	$5,632.28	$1,018,602,600
2013-14 *	4	55,660	28.59	$181.93	$5,200.76	$868,392,400
2013-14 *	TOTAL	60,550	32.16	$181.42	$5,834.13	$4,239,391,500
2014-15 **	1	61,260	35.46	$196.14	$6,955.90	$1,278,424,000
2014-15 **	2	60,590	31.62	$185.06	$5,851.03	$1,063,537,600
2014-15 **	3	59,500	31.56	$184.24	$5,814.32	$1,037,889,900
2014-15 **	4	59,080	27.86	$182.54	$5,084.71	$901,221,100
2014-15 **	TOTAL	60,110	31.66	$187.48	$5,935.17	$4,281,072,500
2015-16 **	1	61,660	35.92	$185.54	$6,664.42	$1,232,773,000
2015-16 **	2	61,390	33.58	$185.10	$6,215.95	$1,144,815,200
2015-16 **	3	58,700	29.41	$184.40	$5,423.76	$955,130,800
2015-16 **	4	59,880	29.74	$181.85	$5,407.90	$971,505,900
2015-16 **	TOTAL	60,410	32.21	$184.32	$5,937.69	$4,304,224,900

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

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

ICF-DD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	5,480	32.87	$182.16	$5,988.10	$98,426,300
2012-13 *	2	5,460	31.05	$181.66	$5,640.25	$92,415,500
2012-13 *	3	5,440	30.86	$181.73	$5,607.73	$91,495,600
2012-13 *	4	4,940	28.25	$182.85	$5,165.40	$76,561,600
2012-13 *	TOTAL	5,330	30.82	$182.07	$5,611.31	$358,899,100
2013-14 *	1	5,400	36.26	$193.27	$7,008.76	$113,485,900
2013-14 *	2	5,220	31.37	$178.43	$5,597.81	$87,734,500
2013-14 *	3	5,240	31.36	$178.76	$5,605.61	$88,142,500
2013-14 *	4	4,800	28.27	$180.13	$5,091.95	$73,288,400
2013-14 *	TOTAL	5,170	31.93	$183.26	$5,850.91	$362,651,300
2014-15 **	1	5,030	35.51	$178.39	$6,334.12	$95,499,200
2014-15 **	2	5,170	31.49	$179.05	$5,638.33	$87,400,000
2014-15 **	3	5,180	30.95	$179.04	$5,541.60	$86,045,600
2014-15 **	4	5,140	26.85	$179.29	$4,813.62	$74,198,900
2014-15 **	TOTAL	5,130	31.18	$178.92	$5,577.80	$343,143,700
2015-16 **	1	5,150	36.47	$179.27	$6,537.23	$101,085,600
2015-16 **	2	5,230	33.79	$178.98	$6,047.33	$94,798,600
2015-16 **	3	5,160	28.52	$179.08	$5,107.54	$79,041,200
2015-16 **	4	5,200	29.09	$179.30	$5,215.92	$81,313,100
2015-16 **	TOTAL	5,180	31.97	$179.16	$5,726.94	$356,238,500

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

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

MEDICAL TRANSPORTATION

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	38,820	3.65	$94.09	$343.39	$39,991,700
2012-13 *	2	35,740	3.61	$93.96	$339.53	$36,399,500
2012-13 *	3	38,270	3.48	$93.44	$324.86	$37,296,200
2012-13 *	4	34,350	3.31	$93.79	$310.14	$31,961,300
2012-13 *	TOTAL	36,790	3.52	$93.82	$329.87	$145,648,800
2013-14 *	1	38,690	3.93	$93.20	$366.55	$42,549,700
2013-14 *	2	34,170	3.81	$83.96	$320.26	$32,829,600
2013-14 *	3	36,910	3.78	$78.96	$298.35	$33,032,700
2013-14 *	4	31,200	3.66	$79.57	$291.36	$27,274,400
2013-14 *	TOTAL	35,240	3.80	$84.35	$320.83	$135,686,500
2014-15 **	1	35,160	4.25	$81.92	$348.41	$36,745,000
2014-15 **	2	32,380	4.02	$79.97	$321.17	$31,202,200
2014-15 **	3	35,180	3.88	$78.88	$305.94	$32,285,700
2014-15 **	4	30,670	3.73	$80.69	$301.29	$27,726,200
2014-15 **	TOTAL	33,350	3.98	$80.40	$319.76	$127,959,100
2015-16 **	1	36,210	4.35	$80.87	$351.41	$38,177,900
2015-16 **	2	33,920	4.19	$80.12	$335.54	$34,145,600
2015-16 **	3	33,610	3.79	$78.96	$299.58	$30,208,300
2015-16 **	4	32,280	3.88	$80.68	$313.35	$30,344,300
2015-16 **	TOTAL	34,010	4.06	$80.19	$325.61	$132,876,200

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

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

OTHER SERVICES

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	217,450	3.16	$120.97	$382.24	$249,358,500
2012-13 *	2	197,550	2.86	$120.04	$343.62	$203,643,600
2012-13 *	3	179,900	3.04	$100.45	$305.34	$164,790,800
2012-13 *	4	214,380	3.48	$74.12	$257.86	$165,840,500
2012-13 *	TOTAL	202,320	3.15	$102.63	$322.77	$783,633,500
2013-14 *	1	216,820	3.42	$96.81	$330.88	$215,227,700
2013-14 *	2	217,900	3.25	$86.75	$281.69	$184,138,500
2013-14 *	3	225,170	3.11	$85.01	$264.07	$178,384,600
2013-14 *	4	205,420	3.38	$77.67	$262.62	$161,842,400
2013-14 *	TOTAL	216,330	3.29	$86.73	$284.90	$739,593,200
2014-15 **	1	211,840	3.57	$99.41	$354.57	$225,337,600
2014-15 **	2	219,100	3.42	$87.71	$300.05	$197,227,300
2014-15 **	3	230,930	3.40	$84.16	$285.98	$198,125,800
2014-15 **	4	221,110	3.69	$73.93	$272.94	$181,046,500
2014-15 **	TOTAL	220,750	3.52	$86.04	$302.66	$801,737,300
2015-16 **	1	228,850	3.89	$89.80	$349.24	$239,764,000
2015-16 **	2	232,810	3.65	$86.97	$317.54	$221,784,100
2015-16 **	3	220,520	3.53	$83.18	$293.54	$194,198,000
2015-16 **	4	235,140	3.93	$73.22	$287.60	$202,878,600
2015-16 **	TOTAL	229,330	3.75	$83.16	$312.00	$858,624,700

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

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

HOME HEALTH

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	5,040	2.99	$1,339.91	$3,999.70	$60,515,500
2012-13 *	2	4,860	2.83	$1,343.06	$3,800.03	$55,457,600
2012-13 *	3	4,990	2.89	$1,288.25	$3,719.98	$55,717,900
2012-13 *	4	4,370	2.88	$1,300.14	$3,742.71	$49,025,700
2012-13 *	TOTAL	4,820	2.90	$1,318.38	$3,818.56	$220,716,800
2013-14 *	1	4,730	3.50	$1,384.39	$4,847.43	$68,794,700
2013-14 *	2	4,570	3.16	$1,336.48	$4,228.10	$57,937,600
2013-14 *	3	4,770	3.13	$1,311.63	$4,110.79	$58,825,400
2013-14 *	4	4,210	3.03	$1,315.70	$3,980.43	$50,272,900
2013-14 *	TOTAL	4,570	3.21	$1,339.16	$4,300.73	$235,830,500
2014-15 **	1	4,660	3.70	$1,368.16	$5,066.24	$70,834,700
2014-15 **	2	4,480	3.36	$1,350.92	$4,535.04	$60,914,800
2014-15 **	3	4,720	3.38	$1,306.12	$4,414.04	$62,546,700
2014-15 **	4	4,240	3.30	$1,324.83	$4,370.09	$55,610,900
2014-15 **	TOTAL	4,530	3.44	$1,338.35	$4,601.58	$249,907,100
2015-16 **	1	4,700	3.97	$1,383.57	$5,487.39	$77,323,500
2015-16 **	2	4,630	3.67	$1,356.59	$4,980.25	$69,177,700
2015-16 **	3	4,570	3.43	$1,310.41	$4,491.33	$61,583,200
2015-16 **	4	4,390	3.61	$1,329.21	$4,799.42	$63,274,200
2015-16 **	TOTAL	4,570	3.67	$1,346.83	$4,944.87	$271,358,500

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

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

PA-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	165,160	4.72	$119.56	$564.03	$279,465,200
2012-13 *	2	158,670	4.42	$121.00	$535.20	$254,765,900
2012-13 *	3	156,470	4.32	$115.55	$499.57	$234,508,900
2012-13 *	4	137,400	4.05	$115.44	$467.98	$192,909,900
2012-13 *	TOTAL	154,430	4.39	$118.09	$518.93	$961,649,900
2013-14 *	1	154,330	4.91	$128.92	$633.40	$293,267,400
2013-14 *	2	142,410	4.51	$118.10	$533.18	$227,797,200
2013-14 *	3	152,130	4.35	$116.37	$506.08	$230,966,100
2013-14 *	4	135,720	4.26	$118.07	$502.80	$204,728,000
2013-14 *	TOTAL	146,150	4.52	$120.77	$545.53	$956,758,700
2014-15 **	1	146,900	4.99	$131.09	$653.51	$287,994,700
2014-15 **	2	124,960	4.78	$122.60	$585.52	$219,508,200
2014-15 **	3	133,840	4.65	$121.97	$567.75	$227,957,500
2014-15 **	4	119,130	4.54	$123.96	$562.74	$201,115,100
2014-15 **	TOTAL	131,210	4.75	$125.23	$594.85	$936,575,500
2015-16 **	1	135,180	5.32	$126.34	$671.85	$272,453,900
2015-16 **	2	127,440	5.00	$122.72	$614.07	$234,770,700
2015-16 **	3	127,830	4.48	$123.03	$551.45	$211,478,300
2015-16 **	4	122,550	4.73	$123.42	$583.93	$214,677,800
2015-16 **	TOTAL	128,250	4.89	$123.99	$606.49	$933,380,700

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

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

PA-AB

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	8,680	7.38	$169.01	$1,247.47	$32,480,400
2012-13 *	2	8,340	6.90	$169.47	$1,168.56	$29,224,400
2012-13 *	3	8,130	6.82	$168.12	$1,145.79	$27,953,800
2012-13 *	4	7,310	6.55	$168.52	$1,103.29	$24,206,200
2012-13 *	TOTAL	8,120	6.93	$168.80	$1,169.25	$113,864,900
2013-14 *	1	8,080	7.85	$173.06	$1,357.77	$32,895,900
2013-14 *	2	7,570	7.19	$167.71	$1,206.38	$27,409,000
2013-14 *	3	7,800	6.78	$174.79	$1,185.20	$27,750,200
2013-14 *	4	7,100	6.69	$169.90	$1,137.50	$24,225,300
2013-14 *	TOTAL	7,640	7.14	$171.45	$1,224.98	$112,280,400
2014-15 **	1	7,740	7.63	$184.32	$1,405.58	$32,632,100
2014-15 **	2	6,980	7.22	$176.94	$1,278.20	$26,753,800
2014-15 **	3	7,120	7.08	$179.75	$1,273.52	$27,191,900
2014-15 **	4	6,540	6.81	$181.33	$1,234.60	$24,221,200
2014-15 **	TOTAL	7,090	7.20	$180.72	$1,301.72	$110,798,900
2015-16 **	1	7,360	8.11	$184.34	$1,495.30	$33,006,200
2015-16 **	2	7,040	7.65	$182.73	$1,398.08	$29,521,100
2015-16 **	3	6,800	6.81	$186.60	$1,269.96	$25,902,000
2015-16 **	4	6,640	7.18	$186.31	$1,338.38	$26,680,300
2015-16 **	TOTAL	6,960	7.45	$184.88	$1,378.24	$115,109,500

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

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

PA-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	373,210	5.62	$186.78	$1,049.80	$1,175,374,200
2012-13 *	2	363,510	5.34	$188.91	$1,008.42	$1,099,715,800
2012-13 *	3	357,060	5.29	$188.26	$996.31	$1,067,238,700
2012-13 *	4	329,110	5.15	$182.70	$941.06	$929,123,100
2012-13 *	TOTAL	355,720	5.36	$186.78	$1,000.65	$4,271,451,900
2013-14 *	1	366,230	6.01	$197.21	$1,185.38	$1,302,360,300
2013-14 *	2	341,280	5.39	$189.99	$1,023.60	$1,048,003,900
2013-14 *	3	352,000	5.15	$199.38	$1,027.40	$1,084,929,600
2013-14 *	4	319,820	5.01	$192.53	$965.52	$926,371,600
2013-14 *	TOTAL	344,830	5.41	$194.95	$1,054.06	$4,361,665,400
2014-15 **	1	355,640	5.78	$210.22	$1,214.48	$1,295,765,100
2014-15 **	2	329,920	5.44	$203.45	$1,106.99	$1,095,652,600
2014-15 **	3	334,730	5.38	$205.01	$1,102.78	$1,107,413,200
2014-15 **	4	312,490	5.19	$201.27	$1,043.90	$978,620,900
2014-15 **	TOTAL	333,200	5.46	$205.26	$1,119.82	$4,477,451,800
2015-16 **	1	348,970	6.08	$211.90	$1,288.49	$1,348,933,300
2015-16 **	2	333,780	5.77	$210.36	$1,213.96	$1,215,595,900
2015-16 **	3	317,790	5.23	$210.59	$1,102.43	$1,051,040,400
2015-16 **	4	318,360	5.48	$206.47	$1,132.22	$1,081,344,800
2015-16 **	TOTAL	329,730	5.65	$209.94	$1,187.08	$4,696,914,300

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

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

PA-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	177,900	2.47	$153.67	$380.24	$202,935,600
2012-13 *	2	183,000	2.42	$154.03	$373.33	$204,955,100
2012-13 *	3	190,210	2.44	$155.43	$379.99	$216,838,600
2012-13 *	4	170,800	2.48	$148.98	$368.82	$188,985,000
2012-13 *	TOTAL	180,480	2.45	$153.10	$375.72	$813,714,400
2013-14 *	1	187,230	2.53	$163.45	$413.72	$232,379,200
2013-14 *	2	176,070	2.33	$156.09	$363.01	$191,740,000
2013-14 *	3	175,440	2.21	$173.22	$382.78	$201,461,000
2013-14 *	4	163,090	2.21	$167.43	$370.73	$181,392,700
2013-14 *	TOTAL	175,460	2.33	$164.81	$383.27	$806,973,000
2014-15 **	1	185,740	2.30	$187.60	$432.12	$240,782,100
2014-15 **	2	180,010	2.22	$179.80	$399.43	$215,699,900
2014-15 **	3	184,640	2.27	$180.01	$408.75	$226,411,800
2014-15 **	4	169,840	2.26	$170.38	$384.35	$195,836,400
2014-15 **	TOTAL	180,060	2.26	$179.69	$406.69	$878,730,200
2015-16 **	1	192,840	2.37	$185.60	$439.35	$254,164,200
2015-16 **	2	193,370	2.30	$182.18	$418.96	$243,047,900
2015-16 **	3	178,520	2.24	$181.78	$406.32	$217,614,300
2015-16 **	4	182,970	2.33	$173.38	$403.42	$221,439,000
2015-16 **	TOTAL	186,920	2.31	$180.82	$417.40	$936,265,400

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

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

LT-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	36,600	31.90	$160.17	$5,110.25	$561,069,300
2012-13 *	2	36,710	30.15	$181.56	$5,473.60	$602,823,900
2012-13 *	3	36,150	30.57	$160.08	$4,893.15	$530,691,800
2012-13 *	4	33,100	25.44	$160.50	$4,082.97	$405,381,400
2012-13 *	TOTAL	35,640	29.61	$165.82	$4,910.27	$2,099,966,500
2013-14 *	1	36,450	35.94	$161.53	$5,804.94	$634,683,100
2013-14 *	2	35,300	30.41	$162.36	$4,937.91	$522,973,900
2013-14 *	3	34,710	29.78	$159.11	$4,738.91	$493,391,800
2013-14 *	4	31,980	26.65	$161.24	$4,297.07	$412,260,700
2013-14 *	TOTAL	34,610	30.84	$161.09	$4,968.24	$2,063,309,500
2014-15 **	1	33,470	34.49	$175.76	$6,062.53	$608,810,700
2014-15 **	2	31,760	32.34	$162.88	$5,267.54	$501,903,200
2014-15 **	3	31,360	32.27	$161.25	$5,203.56	$489,502,200
2014-15 **	4	29,380	29.56	$162.30	$4,797.74	$422,821,900
2014-15 **	TOTAL	31,490	32.25	$166.01	$5,353.31	$2,023,038,000
2015-16 **	1	32,010	36.93	$164.30	$6,068.23	$582,707,600
2015-16 **	2	31,990	34.72	$163.13	$5,663.51	$543,476,100
2015-16 **	3	30,710	30.16	$161.23	$4,863.24	$448,049,600
2015-16 **	4	29,900	31.61	$162.47	$5,136.05	$460,671,900
2015-16 **	TOTAL	31,150	33.42	$162.89	$5,443.68	$2,034,905,300

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

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

LT-AB

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	200	33.07	$166.61	$5,509.55	$3,322,300
2012-13 *	2	200	32.27	$181.78	$5,865.50	$3,484,100
2012-13 *	3	190	31.80	$165.83	$5,273.83	$3,069,400
2012-13 *	4	190	27.48	$171.34	$4,708.50	$2,632,100
2012-13 *	TOTAL	190	31.21	$171.39	$5,349.78	$12,507,800
2013-14 *	1	200	37.01	$172.23	$6,374.40	$3,748,100
2013-14 *	2	190	31.34	$165.76	$5,194.55	$3,023,200
2013-14 *	3	200	31.86	$164.15	$5,229.23	$3,064,300
2013-14 *	4	180	27.69	$166.74	$4,617.23	$2,497,900
2013-14 *	TOTAL	190	32.06	$167.46	$5,369.45	$12,333,600
2014-15 **	1	180	36.44	$181.41	$6,610.65	$3,665,500
2014-15 **	2	190	32.49	$169.76	$5,515.84	$3,083,400
2014-15 **	3	190	31.58	$164.88	$5,206.33	$2,988,900
2014-15 **	4	180	27.95	$163.02	$4,556.51	$2,492,400
2014-15 **	TOTAL	190	32.12	$170.37	$5,473.16	$12,230,200
2015-16 **	1	190	36.17	$166.24	$6,012.51	$3,449,700
2015-16 **	2	190	33.87	$169.43	$5,738.19	$3,311,600
2015-16 **	3	190	29.27	$165.01	$4,829.04	$2,760,500
2015-16 **	4	180	29.78	$163.11	$4,857.71	$2,681,400
2015-16 **	TOTAL	190	32.30	$166.11	$5,365.21	$12,203,200

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

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

LT-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	11,560	32.89	$193.87	$6,375.65	$221,177,700
2012-13 *	2	11,560	31.62	$213.23	$6,741.60	$233,704,200
2012-13 *	3	11,450	31.67	$197.78	$6,264.06	$215,214,100
2012-13 *	4	10,800	26.67	$202.02	$5,388.24	$174,654,500
2012-13 *	TOTAL	11,340	30.78	$201.63	$6,205.56	$844,750,600
2013-14 *	1	11,610	36.69	$197.44	$7,244.64	$252,265,500
2013-14 *	2	11,360	32.08	$196.56	$6,304.71	$214,814,100
2013-14 *	3	11,200	30.89	$199.38	$6,159.26	$206,945,000
2013-14 *	4	10,440	27.16	$198.81	$5,399.50	$169,150,000
2013-14 *	TOTAL	11,150	31.83	$197.96	$6,300.86	$843,174,600
2014-15 **	1	10,820	35.73	$211.66	$7,562.49	$245,526,500
2014-15 **	2	10,360	34.00	$205.45	$6,984.76	$217,183,600
2014-15 **	3	10,250	33.46	$204.20	$6,832.36	$210,113,400
2014-15 **	4	9,800	29.99	$202.39	$6,070.10	$178,375,700
2014-15 **	TOTAL	10,310	33.37	$206.23	$6,881.22	$851,199,200
2015-16 **	1	10,480	38.04	$204.72	$7,787.48	$244,766,000
2015-16 **	2	10,400	36.47	$206.08	$7,515.26	$234,412,200
2015-16 **	3	10,060	31.28	$204.95	$6,409.85	$193,481,000
2015-16 **	4	9,920	32.11	$201.95	$6,485.21	$192,990,000
2015-16 **	TOTAL	10,210	34.53	$204.51	$7,062.74	$865,649,200

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

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

POV 250

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	0		$0.00	$0.00	$0
2012-13 *	2	0		$0.00	$0.00	$0
2012-13 *	3	4,930	2.40	$99.30	$238.31	$3,524,300
2012-13 *	4	26,800	2.42	$113.83	$275.48	$22,150,400
2012-13 *	TOTAL	7,930	2.42	$111.59	$269.70	$25,674,700
2013-14 *	1	49,380	2.34	$137.86	$322.89	$47,834,500
2013-14 *	2	59,680	2.37	$126.20	$298.75	$53,491,100
2013-14 *	3	65,090	2.29	$154.20	$352.57	$68,845,800
2013-14 *	4	68,560	2.28	$140.33	$320.46	$65,915,400
2013-14 *	TOTAL	60,680	2.32	$139.94	$324.23	$236,086,800
2014-15 **	1	88,140	2.38	$162.02	$385.42	$101,912,000
2014-15 **	2	85,440	2.44	$148.66	$362.75	$92,980,100
2014-15 **	3	82,360	2.32	$157.00	$364.75	$90,116,200
2014-15 **	4	78,230	2.37	$147.34	$349.91	$82,117,400
2014-15 **	TOTAL	83,540	2.38	$153.88	$366.21	$367,125,800
2015-16 **	1	94,770	2.40	$152.78	$367.34	$104,436,300
2015-16 **	2	97,020	2.43	$149.29	$362.55	$105,526,800
2015-16 **	3	86,640	2.31	$157.50	$363.32	$94,438,700
2015-16 **	4	89,510	2.36	$148.12	$349.81	$93,934,200
2015-16 **	TOTAL	91,990	2.38	$151.79	$360.87	$398,336,000

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

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

MN-OAS

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	80,980	4.79	$129.92	$622.80	$151,310,900
2012-13 *	2	79,640	4.51	$133.72	$603.19	$144,119,300
2012-13 *	3	78,270	4.45	$129.29	$575.21	$135,071,500
2012-13 *	4	70,230	4.20	$130.51	$547.75	$115,407,600
2012-13 *	TOTAL	77,280	4.50	$130.87	$588.65	$545,909,300
2013-14 *	1	81,640	4.96	$143.18	$710.80	$174,095,800
2013-14 *	2	76,440	4.56	$132.48	$604.46	$138,616,900
2013-14 *	3	79,670	4.42	$135.66	$599.98	$143,394,400
2013-14 *	4	73,880	4.50	$135.12	$607.46	$134,633,400
2013-14 *	TOTAL	77,910	4.62	$136.88	$631.88	$590,740,600
2014-15 **	1	86,800	5.01	$144.40	$722.89	$188,244,700
2014-15 **	2	80,120	4.53	$135.18	$612.95	$147,322,400
2014-15 **	3	83,310	4.42	$136.46	$603.65	$150,862,100
2014-15 **	4	76,440	4.34	$138.01	$598.93	$137,350,000
2014-15 **	TOTAL	81,670	4.59	$138.79	$636.51	$623,779,200
2015-16 **	1	88,080	4.97	$138.65	$689.14	$182,089,200
2015-16 **	2	84,910	4.64	$134.77	$625.56	$159,349,900
2015-16 **	3	82,240	4.22	$136.46	$575.81	$142,067,000
2015-16 **	4	81,020	4.44	$136.87	$607.03	$147,542,900
2015-16 **	TOTAL	84,060	4.57	$136.75	$625.58	$631,049,000

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

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

MN-AB

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	220	6.78	$262.59	$1,780.50	$1,200,100
2012-13 *	2	210	6.70	$244.88	$1,640.71	$1,028,700
2012-13 *	3	200	7.80	$220.41	$1,719.50	$1,038,600
2012-13 *	4	210	7.58	$223.25	$1,691.90	$1,079,400
2012-13 *	TOTAL	210	7.20	$237.30	$1,709.32	$4,346,800
2013-14 *	1	240	8.39	$223.41	$1,874.88	$1,348,000
2013-14 *	2	220	8.51	$251.34	$2,137.72	$1,425,900
2013-14 *	3	210	8.10	$215.68	$1,747.55	$1,074,700
2013-14 *	4	170	7.39	$184.03	$1,359.50	$694,700
2013-14 *	TOTAL	210	8.15	$222.01	$1,808.66	$4,543,300
2014-15 **	1	200	9.80	$203.98	$1,999.80	$1,203,400
2014-15 **	2	210	8.65	$194.22	$1,680.86	$1,049,000
2014-15 **	3	220	8.25	$206.52	$1,702.87	$1,127,900
2014-15 **	4	210	8.13	$194.21	$1,578.09	$1,003,600
2014-15 **	TOTAL	210	8.69	$199.91	$1,736.78	$4,384,000
2015-16 **	1	240	8.84	$197.29	$1,743.15	$1,277,600
2015-16 **	2	240	8.56	$195.49	$1,673.97	$1,187,700
2015-16 **	3	220	7.82	$211.35	$1,653.73	$1,089,000
2015-16 **	4	220	8.23	$196.40	$1,616.97	$1,078,300
2015-16 **	TOTAL	230	8.38	$199.73	$1,673.74	$4,632,600

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

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

MN-ATD

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	68,870	5.90	$257.05	$1,516.53	$313,336,400
2012-13 *	2	68,290	5.55	$260.39	$1,444.03	$295,859,100
2012-13 *	3	66,040	5.51	$257.96	$1,422.58	$281,860,700
2012-13 *	4	61,080	5.49	$243.34	$1,336.10	$244,812,800
2012-13 *	TOTAL	66,070	5.62	$255.03	$1,432.62	$1,135,868,900
2013-14 *	1	68,590	6.22	$253.95	$1,580.78	$325,256,300
2013-14 *	2	64,300	5.66	$246.10	$1,392.00	$268,522,900
2013-14 *	3	66,190	5.48	$255.99	$1,402.40	$278,455,400
2013-14 *	4	59,860	5.34	$231.34	$1,236.13	$221,966,700
2013-14 *	TOTAL	64,730	5.69	$247.61	$1,408.63	$1,094,201,200
2014-15 **	1	66,500	5.95	$237.96	$1,415.74	$282,421,800
2014-15 **	2	62,280	5.67	$247.19	$1,402.59	$262,054,600
2014-15 **	3	63,900	5.60	$249.18	$1,395.95	$267,597,400
2014-15 **	4	60,080	5.49	$235.87	$1,294.19	$233,279,100
2014-15 **	TOTAL	63,190	5.68	$242.55	$1,378.60	$1,045,352,900
2015-16 **	1	68,130	6.38	$239.75	$1,530.28	$312,788,700
2015-16 **	2	66,770	5.98	$246.95	$1,476.58	$295,758,300
2015-16 **	3	64,570	5.43	$246.70	$1,339.34	$259,453,700
2015-16 **	4	65,000	5.75	$234.48	$1,349.41	$263,130,600
2015-16 **	TOTAL	66,120	5.89	$241.89	$1,425.65	$1,131,131,300

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

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

MN-AFDC

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	468,560	2.85	$185.24	$527.33	$741,246,400
2012-13 *	2	472,110	2.73	$185.65	$507.26	$718,454,600
2012-13 *	3	484,110	2.73	$184.67	$503.63	$731,445,800
2012-13 *	4	439,000	2.71	$176.73	$478.21	$629,810,300
2012-13 *	TOTAL	465,950	2.75	$183.23	$504.52	$2,820,957,100
2013-14 *	1	500,460	2.88	$188.84	$543.08	$815,371,900
2013-14 *	2	460,270	2.63	$186.75	$490.36	$677,095,500
2013-14 *	3	448,160	2.51	$208.12	$522.54	$702,539,000
2013-14 *	4	395,470	2.42	$197.67	$479.21	$568,541,500
2013-14 *	TOTAL	451,090	2.62	$194.68	$510.53	$2,763,547,900
2014-15 **	1	471,220	2.61	$210.98	$550.04	$777,565,800
2014-15 **	2	452,830	2.52	$210.22	$530.00	$719,993,000
2014-15 **	3	457,970	2.50	$210.34	$526.61	$723,512,300
2014-15 **	4	414,630	2.47	$197.85	$489.18	$608,478,600
2014-15 **	TOTAL	449,160	2.53	$207.66	$524.97	$2,829,549,700
2015-16 **	1	484,710	2.72	$210.13	$572.00	$831,763,000
2015-16 **	2	477,710	2.58	$212.47	$548.52	$786,100,500
2015-16 **	3	432,690	2.45	$213.10	$521.53	$676,982,200
2015-16 **	4	437,510	2.53	$200.71	$507.36	$665,919,200
2015-16 **	TOTAL	458,160	2.57	$209.20	$538.53	$2,960,764,900

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

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

MI-C

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	77,770	2.67	$147.82	$395.02	$92,161,500
2012-13 *	2	76,460	2.64	$149.40	$393.68	$90,299,200
2012-13 *	3	78,210	2.74	$153.28	$419.62	$98,452,200
2012-13 *	4	69,810	2.67	$146.88	$392.88	$82,286,000
2012-13 *	TOTAL	75,560	2.68	$149.44	$400.55	$363,198,900
2013-14 *	1	83,170	2.73	$144.83	$394.76	$98,498,700
2013-14 *	2	77,500	2.64	$140.69	$370.74	$86,195,000
2013-14 *	3	93,210	2.83	$133.55	$377.87	$105,658,800
2013-14 *	4	83,320	2.75	$139.78	$385.04	$96,238,300
2013-14 *	TOTAL	84,300	2.74	$139.45	$382.17	$386,590,700
2014-15 **	1	90,440	2.71	$141.99	$385.07	$104,480,500
2014-15 **	2	77,850	2.66	$143.10	$380.10	$88,775,500
2014-15 **	3	76,460	2.77	$140.75	$390.36	$89,540,300
2014-15 **	4	63,880	2.74	$140.37	$384.64	$73,710,800
2014-15 **	TOTAL	77,160	2.72	$141.61	$385.04	$356,507,200
2015-16 **	1	81,430	2.82	$141.27	$398.17	$97,275,000
2015-16 **	2	79,650	2.76	$143.43	$395.21	$94,436,800
2015-16 **	3	70,750	2.76	$141.66	$391.42	$83,075,000
2015-16 **	4	68,070	2.79	$142.03	$396.66	$80,998,700
2015-16 **	TOTAL	74,970	2.78	$142.10	$395.45	$355,785,500

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

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

MI-A

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	1,570	13.43	$200.08	$2,687.45	$12,631,000
2012-13 *	2	1,610	10.46	$194.65	$2,036.06	$9,824,000
2012-13 *	3	1,620	14.16	$217.14	$3,074.53	$14,948,400
2012-13 *	4	1,470	12.29	$198.60	$2,441.55	$10,755,000
2012-13 *	TOTAL	1,570	12.59	$203.55	$2,562.71	$48,158,400
2013-14 *	1	1,770	16.71	$199.00	$3,325.21	$17,663,500
2013-14 *	2	1,710	11.88	$190.40	$2,262.63	$11,614,100
2013-14 *	3	1,540	10.71	$205.49	$2,201.28	$10,156,700
2013-14 *	4	1,150	13.98	$200.25	$2,799.61	$9,689,500
2013-14 *	TOTAL	1,540	13.37	$198.42	$2,652.47	$49,123,800
2014-15 **	1	1,010	14.59	$219.19	$3,197.86	$9,706,300
2014-15 **	2	950	17.95	$220.55	$3,958.41	$11,287,100
2014-15 **	3	920	16.87	$232.96	$3,931.10	$10,878,900
2014-15 **	4	860	17.49	$211.07	$3,691.73	$9,562,400
2014-15 **	TOTAL	940	16.67	$221.03	$3,684.95	$41,434,800
2015-16 **	1	1,050	18.66	$216.52	$4,040.70	$12,687,200
2015-16 **	2	1,000	18.53	$220.60	$4,088.13	$12,295,300
2015-16 **	3	870	16.02	$234.11	$3,749.44	$9,783,200
2015-16 **	4	920	17.86	$210.89	$3,766.50	$10,418,900
2015-16 **	TOTAL	960	17.84	$219.85	$3,921.30	$45,184,500

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

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

REFUGEE

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	550	2.90	$111.14	$322.31	$528,900
2012-13 *	2	730	2.91	$135.51	$395.01	$859,200
2012-13 *	3	860	2.63	$125.90	$330.86	$855,600
2012-13 *	4	720	2.78	$122.81	$341.07	$740,800
2012-13 *	TOTAL	710	2.79	$124.73	$348.08	$2,984,500
2013-14 *	1	840	2.82	$197.90	$558.89	$1,405,100
2013-14 *	2	630	2.78	$145.04	$402.95	$764,800
2013-14 *	3	660	2.62	$138.13	$361.99	$713,800
2013-14 *	4	640	2.83	$137.20	$388.72	$750,600
2013-14 *	TOTAL	690	2.77	$157.93	$437.08	$3,634,300
2014-15 **	1	640	2.70	$125.30	$337.95	$653,200
2014-15 **	2	700	2.77	$139.12	$384.70	$811,900
2014-15 **	3	910	2.30	$134.26	$308.26	$840,900
2014-15 **	4	820	2.39	$140.13	$335.44	$829,400
2014-15 **	TOTAL	770	2.51	$134.97	$339.19	$3,135,400
2015-16 **	1	910	2.55	$126.15	$321.22	$873,200
2015-16 **	2	810	2.79	$135.25	$377.23	$916,000
2015-16 **	3	840	2.28	$135.98	$310.28	$786,500
2015-16 **	4	820	2.59	$140.66	$364.64	$901,100
2015-16 **	TOTAL	850	2.55	$134.32	$342.45	$3,476,800

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

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

OBRA

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	15,370	5.50	$272.70	$1,500.62	$69,184,600
2012-13 *	2	15,250	5.31	$287.60	$1,527.93	$69,910,600
2012-13 *	3	14,840	5.32	$260.99	$1,389.10	$61,846,900
2012-13 *	4	13,090	5.03	$268.16	$1,347.65	$52,918,100
2012-13 *	TOTAL	14,640	5.30	$272.65	$1,445.27	$253,860,300
2013-14 *	1	15,160	5.96	$246.29	$1,468.39	$66,776,500
2013-14 *	2	14,610	5.66	$244.88	$1,385.79	$60,734,900
2013-14 *	3	18,930	5.17	$248.57	$1,286.25	$73,048,500
2013-14 *	4	23,540	4.64	$222.89	$1,035.15	$73,103,500
2013-14 *	TOTAL	18,060	5.27	$239.84	$1,262.77	$273,663,500
2014-15 **	1	33,090	5.19	$230.68	$1,197.62	$118,901,300
2014-15 **	2	36,620	4.76	$240.37	$1,143.14	$125,586,600
2014-15 **	3	37,880	4.62	$252.66	$1,166.10	$132,513,600
2014-15 **	4	35,420	4.43	$261.97	$1,160.39	$123,299,200
2014-15 **	TOTAL	35,750	4.74	$246.08	$1,166.10	$500,300,700
2015-16 **	1	38,880	5.07	$250.62	$1,270.73	$148,235,800
2015-16 **	2	38,580	4.96	$251.59	$1,246.86	$144,313,200
2015-16 **	3	37,390	4.49	$260.58	$1,170.97	$131,336,700
2015-16 **	4	36,250	4.64	$261.88	$1,215.88	$132,213,600
2015-16 **	TOTAL	37,770	4.80	$255.80	$1,226.79	$556,099,200

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

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

POV 185

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	125,790	3.40	$186.02	$633.28	$238,970,900
2012-13 *	2	123,760	3.36	$192.40	$646.57	$240,058,700
2012-13 *	3	129,140	3.31	$192.14	$635.44	$246,188,900
2012-13 *	4	113,550	3.14	$193.33	$606.33	$206,542,400
2012-13 *	TOTAL	123,060	3.31	$190.86	$630.97	$931,760,800
2013-14 *	1	132,040	3.57	$187.10	$668.77	$264,920,600
2013-14 *	2	126,050	3.41	$183.48	$625.09	$236,381,300
2013-14 *	3	125,280	3.42	$201.08	$686.80	$258,129,200
2013-14 *	4	112,780	3.22	$197.18	$634.49	$214,674,900
2013-14 *	TOTAL	124,040	3.41	$191.88	$654.43	$974,106,000
2014-15 **	1	158,570	3.30	$202.91	$668.69	$318,111,500
2014-15 **	2	149,060	3.41	$202.94	$691.88	$309,397,100
2014-15 **	3	154,220	3.37	$204.67	$690.54	$319,481,900
2014-15 **	4	139,340	3.19	$200.65	$640.37	$267,697,200
2014-15 **	TOTAL	150,300	3.32	$202.87	$673.48	$1,214,687,600
2015-16 **	1	168,660	3.48	$199.42	$694.17	$351,227,200
2015-16 **	2	162,670	3.47	$204.47	$709.42	$346,204,200
2015-16 **	3	151,700	3.28	$209.21	$685.89	$312,157,100
2015-16 **	4	151,540	3.25	$202.69	$658.16	$299,217,000
2015-16 **	TOTAL	158,640	3.37	$203.77	$687.50	$1,308,805,600

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

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

POV 133

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	18,260	2.02	$133.83	$269.86	$14,779,700
2012-13 *	2	19,250	1.97	$128.56	$253.86	$14,663,800
2012-13 *	3	20,610	2.04	$124.32	$253.28	$15,664,000
2012-13 *	4	18,910	2.10	$121.97	$255.56	$14,495,600
2012-13 *	TOTAL	19,260	2.03	$126.99	$257.92	$59,603,200
2013-14 *	1	21,310	2.03	$134.67	$273.45	$17,484,500
2013-14 *	2	19,930	1.95	$131.99	$257.54	$15,394,500
2013-14 *	3	19,610	1.91	$136.09	$259.63	$15,273,000
2013-14 *	4	17,430	1.97	$133.14	$261.98	$13,696,900
2013-14 *	TOTAL	19,570	1.97	$134.00	$263.38	$61,849,000
2014-15 **	1	21,290	1.99	$157.55	$313.64	$20,028,200
2014-15 **	2	23,080	1.90	$157.80	$299.76	$20,753,800
2014-15 **	3	23,340	1.90	$155.33	$294.79	$20,644,100
2014-15 **	4	19,890	1.92	$146.05	$279.87	$16,702,200
2014-15 **	TOTAL	21,900	1.93	$154.43	$297.29	$78,128,300
2015-16 **	1	22,670	2.01	$156.77	$315.08	$21,427,400
2015-16 **	2	23,970	1.94	$162.13	$313.79	$22,567,600
2015-16 **	3	21,750	1.86	$158.29	$294.25	$19,199,500
2015-16 **	4	20,720	1.94	$149.96	$290.55	$18,057,100
2015-16 **	TOTAL	22,280	1.94	$156.98	$303.95	$81,251,700

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

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

POV 100

		AVERAGE MONTHLY				
YEAR	QUARTER	USERS	UNITS PER USER	COST PER UNIT	COST PER USER	TOTAL COST
2012-13 *	1	17,110	2.32	$150.16	$347.76	$17,847,500
2012-13 *	2	17,630	2.29	$152.40	$349.72	$18,498,900
2012-13 *	3	18,410	2.31	$156.47	$361.82	$19,985,900
2012-13 *	4	18,250	2.41	$133.40	$321.58	$17,606,000
2012-13 *	TOTAL	17,850	2.33	$147.89	$345.18	$73,938,400
2013-14 *	1	21,580	2.37	$151.37	$358.87	$23,236,000
2013-14 *	2	21,150	2.27	$149.54	$339.07	$21,511,000
2013-14 *	3	20,960	2.18	$145.76	$317.24	$19,950,700
2013-14 *	4	21,330	2.20	$137.78	$303.59	$19,429,300
2013-14 *	TOTAL	21,260	2.26	$146.24	$329.81	$84,126,900
2014-15 **	1	31,130	2.21	$154.45	$341.18	$31,860,200
2014-15 **	2	32,870	2.18	$152.06	$331.16	$32,653,600
2014-15 **	3	32,350	2.15	$148.86	$319.44	$30,998,500
2014-15 **	4	28,430	2.22	$138.76	$307.74	$26,244,700
2014-15 **	TOTAL	31,190	2.19	$148.78	$325.29	$121,757,000
2015-16 **	1	32,420	2.32	$155.57	$360.68	$35,081,500
2015-16 **	2	33,180	2.22	$159.95	$354.95	$35,332,600
2015-16 **	3	29,680	2.10	$151.85	$319.19	$28,420,300
2015-16 **	4	28,510	2.24	$146.63	$328.91	$28,136,500
2015-16 **	TOTAL	30,950	2.22	$153.82	$341.88	$126,970,900

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

Medi-Cal Base Policy Changes

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

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

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

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

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL			
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	$80,919,000	$56,519,000	$24,400,000
63	NARCOTIC TREATMENT PROGRAM	$72,494,000	$72,494,000	$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$33,512,000	$33,512,000	$0
65	RESIDENTIAL TREATMENT SERVICES	$5,792,000	$5,792,000	$0
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,850,000	-$27,850,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$164,867,000**	**$140,467,000**	**$24,400,000**
	MENTAL HEALTH			
69	SMHS FOR ADULTS	$1,022,775,000	$953,411,000	$69,364,000
70	SMHS FOR CHILDREN	$938,451,000	$901,603,000	$36,848,000
	MENTAL HEALTH SUBTOTAL	**$1,961,226,000**	**$1,855,014,000**	**$106,212,000**
	MANAGED CARE			
109	TWO PLAN MODEL	$9,161,871,000	$4,746,037,650	$4,415,833,350
111	COUNTY ORGANIZED HEALTH SYSTEMS	$4,610,126,000	$2,370,012,250	$2,240,113,750
112	GEOGRAPHIC MANAGED CARE	$1,769,845,000	$912,629,900	$857,215,100
116	REGIONAL MODEL	$388,003,000	$202,760,950	$185,242,050
119	PACE (Other M/C)	$242,264,000	$121,132,000	$121,132,000
120	DENTAL MANAGED CARE (Other M/C)	$102,736,000	$51,368,000	$51,368,000
121	SENIOR CARE ACTION NETWORK (Other M/C)	$44,222,000	$22,111,000	$22,111,000
125	AIDS HEALTHCARE CENTERS (Other M/C)	$8,171,000	$4,085,500	$4,085,500
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,065,000	$532,500	$532,500
	MANAGED CARE SUBTOTAL	**$16,328,303,000**	**$8,430,669,750**	**$7,897,633,250**
	OTHER			
167	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,261,974,000	$3,261,974,000	$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,598,884,000	$1,205,387,500	$1,393,496,500
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,537,016,000	$0	$1,537,016,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,359,930,000	$1,359,930,000	$0
171	DENTAL SERVICES	$795,450,000	$417,817,750	$377,632,250
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$265,000,000	$265,000,000	$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$191,787,000	$191,787,000	$0
177	MEDI-CAL TCM PROGRAM	$41,394,000	$41,394,000	$0
178	EPSDT SCREENS	$39,065,000	$19,994,650	$19,070,350
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$38,831,000	$19,415,500	$19,415,500
183	LAWSUITS/CLAIMS	$7,921,000	$3,961,500	$3,959,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,243,000	$1,121,500	$1,121,500
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,799,000	$1,799,000	$0
195	BASE RECOVERIES	-$268,768,000	-$133,486,000	-$135,282,000
	OTHER SUBTOTAL	**$9,872,526,000**	**$6,656,096,400**	**$3,216,429,600**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2014-15

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	GRAND TOTAL	**$28,326,922,000**	**$17,082,247,150**	**$11,244,674,850**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL			
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	$105,657,000	$72,846,000	$32,811,000
63	NARCOTIC TREATMENT PROGRAM	$77,949,000	$77,949,000	$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$36,657,000	$36,657,000	$0
65	RESIDENTIAL TREATMENT SERVICES	$63,887,000	$44,277,000	$19,610,000
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,850,000	-$27,850,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$256,300,000**	**$203,879,000**	**$52,421,000**
	MENTAL HEALTH			
69	SMHS FOR ADULTS	$1,145,028,000	$1,073,208,000	$71,820,000
70	SMHS FOR CHILDREN	$990,486,000	$951,132,000	$39,354,000
	MENTAL HEALTH SUBTOTAL	**$2,135,514,000**	**$2,024,340,000**	**$111,174,000**
	MANAGED CARE			
109	TWO PLAN MODEL	$9,425,937,000	$4,878,166,200	$4,547,770,800
111	COUNTY ORGANIZED HEALTH SYSTEMS	$4,652,444,000	$2,392,388,700	$2,260,055,300
112	GEOGRAPHIC MANAGED CARE	$1,819,186,000	$937,810,500	$881,375,500
116	REGIONAL MODEL	$388,228,000	$203,890,050	$184,337,950
119	PACE (Other M/C)	$315,767,000	$157,883,500	$157,883,500
120	DENTAL MANAGED CARE (Other M/C)	$103,902,000	$51,951,000	$51,951,000
121	SENIOR CARE ACTION NETWORK (Other M/C)	$43,997,000	$21,998,500	$21,998,500
125	AIDS HEALTHCARE CENTERS (Other M/C)	$7,003,000	$3,501,500	$3,501,500
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,065,000	$532,500	$532,500
	MANAGED CARE SUBTOTAL	**$16,757,529,000**	**$8,648,122,450**	**$8,109,406,550**
	OTHER			
167	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,417,045,000	$3,417,045,000	$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,637,307,000	$1,222,159,000	$1,415,148,000
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,641,475,000	$0	$1,641,475,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,514,429,000	$1,514,429,000	$0
171	DENTAL SERVICES	$823,747,000	$430,762,050	$392,984,950
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$265,000,000	$265,000,000	$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$153,558,000	$153,558,000	$0
177	MEDI-CAL TCM PROGRAM	$44,292,000	$44,292,000	$0
178	EPSDT SCREENS	$39,065,000	$19,994,650	$19,070,350
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$40,858,000	$20,429,000	$20,429,000
183	LAWSUITS/CLAIMS	$1,865,000	$932,500	$932,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,356,000	$1,178,000	$1,178,000
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,285,000	$1,285,000	$0
195	BASE RECOVERIES	-$265,697,000	-$131,961,000	-$133,736,000
	OTHER SUBTOTAL	**$10,316,585,000**	**$6,959,103,200**	**$3,357,481,800**

SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
	GRAND TOTAL	**$29,465,928,000**	**$17,835,444,650**	**$11,630,483,350**

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL						
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	$66,590,000	$20,321,000	$80,919,000	$24,400,000	$14,329,000	$4,079,000
63	NARCOTIC TREATMENT PROGRAM	$24,584,000	$0	$72,494,000	$0	$47,910,000	$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$26,379,000	$0	$33,512,000	$0	$7,133,000	$0
65	RESIDENTIAL TREATMENT SERVICES	$111,421,000	$36,914,000	$5,792,000	$0	-$105,629,000	-$36,914,000
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,050,000	$0	-$27,850,000	$0	-$800,000	$0
	DRUG MEDI-CAL SUBTOTAL	**$201,924,000**	**$57,235,000**	**$164,867,000**	**$24,400,000**	**-$37,057,000**	**-$32,835,000**
	MENTAL HEALTH						
69	SMHS FOR ADULTS	$565,334,000	$0	$1,022,775,000	$69,364,000	$457,441,000	$69,364,000
70	SMHS FOR CHILDREN	$875,642,000	$0	$938,451,000	$36,848,000	$62,809,000	$36,848,000
	MENTAL HEALTH SUBTOTAL	**$1,440,976,000**	**$0**	**$1,961,226,000**	**$106,212,000**	**$520,250,000**	**$106,212,000**
	MANAGED CARE						
109	TWO PLAN MODEL	$8,792,854,000	$4,309,888,250	$9,161,871,000	$4,415,833,350	$369,017,000	$105,945,100
111	COUNTY ORGANIZED HEALTH SYSTEMS	$4,307,708,000	$2,112,577,900	$4,610,126,000	$2,240,113,750	$302,418,000	$127,535,850
112	GEOGRAPHIC MANAGED CARE	$1,619,755,000	$792,586,600	$1,769,845,000	$857,215,100	$150,090,000	$64,628,500
116	REGIONAL MODEL	$300,253,000	$145,419,200	$388,003,000	$185,242,050	$87,750,000	$39,822,850
119	PACE (Other M/C)	$243,791,000	$121,895,500	$242,264,000	$121,132,000	-$1,527,000	-$763,500
120	DENTAL MANAGED CARE (Other M/C)	$67,103,000	$33,551,500	$102,736,000	$51,368,000	$35,633,000	$17,816,500
121	SENIOR CARE ACTION NETWORK (Other M/C)	$41,232,000	$20,616,000	$44,222,000	$22,111,000	$2,990,000	$1,495,000
125	AIDS HEALTHCARE CENTERS (Other M/C)	$9,061,000	$4,530,500	$8,171,000	$4,085,500	-$890,000	-$445,000
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,442,000	$721,000	$1,065,000	$532,500	-$377,000	-$188,500
	MANAGED CARE SUBTOTAL	**$15,383,199,000**	**$7,541,786,450**	**$16,328,303,000**	**$7,897,633,250**	**$945,104,000**	**$355,846,800**
	OTHER						
167	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,259,927,000	$0	$3,261,974,000	$0	$2,047,000	$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,575,216,000	$1,372,957,500	$2,598,884,000	$1,393,496,500	$23,668,000	$20,539,000
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,462,530,000	$1,462,530,000	$1,537,016,000	$1,537,016,000	$74,486,000	$74,486,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,406,132,000	$0	$1,359,930,000	$0	-$46,202,000	$0
171	DENTAL SERVICES	$578,288,000	$267,310,900	$795,450,000	$377,632,250	$217,162,000	$110,321,350
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$265,000,000	$0	$265,000,000	$0	$0	$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$158,421,000	$0	$191,787,000	$0	$33,366,000	$0

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

		2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
177	MEDI-CAL TCM PROGRAM	$44,554,000	$0	$41,394,000	$0	-$3,160,000	$0
178	EPSDT SCREENS	$38,799,000	$18,478,650	$39,065,000	$19,070,350	$266,000	$591,700
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$32,158,000	$16,079,000	$38,831,000	$19,415,500	$6,673,000	$3,336,500
183	LAWSUITS/CLAIMS	$7,865,000	$3,932,500	$7,921,000	$3,959,500	$56,000	$27,000
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,478,000	$1,239,000	$2,243,000	$1,121,500	-$235,000	-$117,500
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,285,000	$0	$1,799,000	$0	$514,000	$0
195	BASE RECOVERIES	-$266,285,000	-$134,032,000	-$268,768,000	-$135,282,000	-$2,483,000	-$1,250,000
	OTHER SUBTOTAL	**$9,566,368,000**	**$3,008,495,550**	**$9,872,526,000**	**$3,216,429,600**	**$306,158,000**	**$207,934,050**
	GRAND TOTAL	**$26,592,467,000**	**$10,607,517,000**	**$28,326,922,000**	**$11,244,674,850**	**$1,734,455,000**	**$637,157,850**

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	DRUG MEDI-CAL						
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	$80,919,000	$24,400,000	$105,657,000	$32,811,000	$24,738,000	$8,411,000
63	NARCOTIC TREATMENT PROGRAM	$72,494,000	$0	$77,949,000	$0	$5,455,000	$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	$33,512,000	$0	$36,657,000	$0	$3,145,000	$0
65	RESIDENTIAL TREATMENT SERVICES	$5,792,000	$0	$63,887,000	$19,610,000	$58,095,000	$19,610,000
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-$27,850,000	$0	-$27,850,000	$0	$0	$0
	DRUG MEDI-CAL SUBTOTAL	**$164,867,000**	**$24,400,000**	**$256,300,000**	**$52,421,000**	**$91,433,000**	**$28,021,000**
	MENTAL HEALTH						
69	SMHS FOR ADULTS	$1,022,775,000	$69,364,000	$1,145,028,000	$71,820,000	$122,253,000	$2,456,000
70	SMHS FOR CHILDREN	$938,451,000	$36,848,000	$990,486,000	$39,354,000	$52,035,000	$2,506,000
	MENTAL HEALTH SUBTOTAL	**$1,961,226,000**	**$106,212,000**	**$2,135,514,000**	**$111,174,000**	**$174,288,000**	**$4,962,000**
	MANAGED CARE						
109	TWO PLAN MODEL	$9,161,871,000	$4,415,833,350	$9,425,937,000	$4,547,770,800	$264,066,000	$131,937,450
111	COUNTY ORGANIZED HEALTH SYSTEMS	$4,610,126,000	$2,240,113,750	$4,652,444,000	$2,260,055,300	$42,318,000	$19,941,550
112	GEOGRAPHIC MANAGED CARE	$1,769,845,000	$857,215,100	$1,819,186,000	$881,375,500	$49,341,000	$24,160,400
116	REGIONAL MODEL	$388,003,000	$185,242,050	$388,228,000	$184,337,950	$225,000	-$904,100
119	PACE (Other M/C)	$242,264,000	$121,132,000	$315,767,000	$157,883,500	$73,503,000	$36,751,500
120	DENTAL MANAGED CARE (Other M/C)	$102,736,000	$51,368,000	$103,902,000	$51,951,000	$1,166,000	$583,000
121	SENIOR CARE ACTION NETWORK (Other M/C)	$44,222,000	$22,111,000	$43,997,000	$21,998,500	-$225,000	-$112,500
125	AIDS HEALTHCARE CENTERS (Other M/C)	$8,171,000	$4,085,500	$7,003,000	$3,501,500	-$1,168,000	-$584,000
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	$1,065,000	$532,500	$1,065,000	$532,500	$0	$0
	MANAGED CARE SUBTOTAL	**$16,328,303,000**	**$7,897,633,250**	**$16,757,529,000**	**$8,109,406,550**	**$429,226,000**	**$211,773,300**
	OTHER						
167	PERSONAL CARE SERVICES (Misc. Svcs.)	$3,261,974,000	$0	$3,417,045,000	$0	$155,071,000	$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	$2,598,884,000	$1,393,496,500	$2,637,307,000	$1,415,148,000	$38,423,000	$21,651,500
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	$1,537,016,000	$1,537,016,000	$1,641,475,000	$1,641,475,000	$104,459,000	$104,459,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	$1,359,930,000	$0	$1,514,429,000	$0	$154,499,000	$0
171	DENTAL SERVICES	$795,450,000	$377,632,250	$823,747,000	$392,984,950	$28,297,000	$15,352,700

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

COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

		NOV. 2014 EST. FOR 2014-15		NOV. 2014 EST. FOR 2015-16		DIFFERENCE	
NO.	POLICY CHANGE TITLE	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
	OTHER						
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	$265,000,000	$0	$265,000,000	$0	$0	$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	$191,787,000	$0	$153,558,000	$0	-$38,229,000	$0
177	MEDI-CAL TCM PROGRAM	$41,394,000	$0	$44,292,000	$0	$2,898,000	$0
178	EPSDT SCREENS	$39,065,000	$19,070,350	$39,065,000	$19,070,350	$0	$0
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	$38,831,000	$19,415,500	$40,858,000	$20,429,000	$2,027,000	$1,013,500
183	LAWSUITS/CLAIMS	$7,921,000	$3,959,500	$1,865,000	$932,500	-$6,056,000	-$3,027,000
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	$2,243,000	$1,121,500	$2,356,000	$1,178,000	$113,000	$56,500
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	$1,799,000	$0	$1,285,000	$0	-$514,000	$0
195	BASE RECOVERIES	-$268,768,000	-$135,282,000	-$265,697,000	-$133,736,000	$3,071,000	$1,546,000
	OTHER SUBTOTAL	**$9,872,526,000**	**$3,216,429,600**	**$10,316,585,000**	**$3,357,481,800**	**$444,059,000**	**$141,052,200**
	GRAND TOTAL	**$28,326,922,000**	**$11,244,674,850**	**$29,465,928,000**	**$11,630,483,350**	**$1,139,006,000**	**$385,808,500**

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

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POLICY CHANGE INDEX

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

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1726

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$80,919,000	$105,657,000
- STATE FUNDS	$24,400,000	$32,811,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$80,919,000	$105,657,000
STATE FUNDS	$24,400,000	$32,811,000
FEDERAL FUNDS	$56,519,000	$72,846,000

DESCRIPTION

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

Authority:
Title 22, California Code of Regulations 51341.1 (b)(8); 51341.1 (d)(3), and 51516.1 (a)

Interdependent Policy Changes:
Not Applicable

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

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

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

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

pregnant and postpartum women.

With the provisions of the Affordable Care Act (ACA), the Department expects new Medi-Cal beneficiaries in the expanded, mandatory and optional populations categories.

The expanded population refers to those who are eligible and enrolled in Medi-Cal now, but are not receiving this service because it was not available to them. Funding for the services is 50% General Funds (GF) and 50% Title XIX FF.

The mandatory expansion population refers to the population currently eligible but not enrolled in Medi-Cal. For this population's services, funding is 50% GF and 50% Title XIX FF. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

The optional expansion population was previously ineligible for Medi-Cal but became eligible starting January 1, 2014. Funding for this population's services is 100% Title XIX FF.

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

Reason for Change from Prior Estimate:

- The Department revised the ACA caseload projections based on enrollment data.
- The Units of Service (UOS) were adjusted using the most current annual client caseload.

Methodology:

1. The DMC eligible clients are categorized into three groups: Regular, EPSDT, and Perinatal.

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

3. The caseload projections are based on the 51 months of the most recent complete caseload data, January 2010 through March 2014.

4. Assume the caseload projection for the expansion population is 14,665 for FYs 2014-15 and 2015-16.

5. Assume mandatory expansion population is 2,555 for FY 2014-15 and 2,754 for FY 2015-16.

6. Assume optional expansion population is 7,206 for FY 2014-15 and 7,316 for FY 2015-16.

7. The UOS is based on the most recent complete data, July 2012-June 2013 to calculate an average UOS.

8. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2014-15 and FY 2015-16 budgeted amounts are based on the FY 2014-15 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

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

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

10. Amounts may differ due to rounding.

			FY 2014-15		FY 2015-16	
	UOS	Rates	Caseload	Total	Caseload	Total
Current						
Regular & EPSDT	69.6	$56.44	5,239	$20,580,000	5,246	$20,607,000
Perinatal	31.5	$80.78	449	$1,143,000	442	$1,125,000
Subtotal			5,688	$21,723,000	5,688	$21,732,000
Expanded						
Regular & EPSDT	69.6	$56.44	13,762	$54,059,000	13,756	$54,036,000
Minor Consent	69.6	$56.44	59	$230,000	59	$230,000
Perinatal	31.5	$80.78	845	$2,149,000	851	$2,164,000
Subtotal			14,665	$56,438,000	14,665	$56,430,000
Mandatory						
Regular & EPSDT	69.6	$56.44	2,399	$9,422,000	2,585	$10,156,000
Minor Consent	69.6	$56.44	10	$40,000	11	$43,000
Perinatal	31.5	$80.78	146	$372,000	158	$401,000
Subtotal			2,555	$9,834,000	2,754	$10,600,000
Optional						
Regular & EPSDT	69.6	$56.44	6,767	$26,582,000	6,878	$27,019,000
Perinatal	31.5	$80.78	440	$1,119,000	438	$1,115,000
Subtotal			7,206	$27,701,000	7,316	$28,134,000
Total				$115,696,000		$116,896,000

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

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

Fiscal Year	Accrual	FY 2014-15	FY 2015-16
Regular	$17,868,000	$4,467,000	
Perinatal	$641,000	$160,250	
FY 2013-14	$18,509,000	$4,627,250	$0
Current			
Regular	$20,580,000	$15,435,000	$5,145,000
Perinatal	$1,143,000	$857,250	$285,750
Expanded			
Regular	$54,059,000	$40,544,250	$13,514,750
Minor Consent	$230,000	$172,500	$57,500
Perinatal	$2,149,000	$1,611,750	$537,250
Mandatory			
Regular	$9,422,000	$7,066,500	$2,355,500
Minor Consent	$40,000	$30,000	$10,000
Perinatal	$372,000	$279,000	$93,000
Optional			
Regular	$26,582,000	$19,936,500	$6,645,500
Perinatal	$1,119,000	$839,250	$279,750
FY 2014-15	$115,696,000	$86,772,000	$28,924,000
Current			
Regular	$20,607,000	$0	$15,455,250
Perinatal	$1,125,000	$0	$843,750
Expanded			
Regular	$54,036,000	$0	$40,527,000
Minor Consent	$230,000	$0	$172,500
Perinatal	$2,164,000	$0	$1,623,000
Mandatory			
Regular	$10,156,000	$0	$7,617,000
Minor Consent	$43,000	$0	$32,250
Perinatal	$401,000	$0	$300,750
Optional			
Regular	$27,019,000	$0	$20,264,250
Perinatal	$1,115,000	$0	$836,250
FY 2015-16	$116,896,000	$0	$87,672,000
Total		$91,399,250	$116,596,000

12. Funding for current beneficiaries is 50% CF and 50% FF. Beneficiaries in the expanded and mandatory categories are funded 50% GF and 50% FF. Minor consent costs are funded by the counties. Beneficiaries in the optional category are funded 100% FF. A portion of children are

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

funded 65% FF and 35% GF and the remaining children population at 50% GF and 50% FF.

FY 2014-15	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Regular	$19,902,000	$9,857,000	$122,000	$9,923,000	$0
Perinatal	$1,017,000	$17,000	$644,000	$356,000	$0
Expanded					
Regular	$40,545,000	$20,082,000	$248,000	$0	$20,215,000
Minor Consent	$173,000	$0	$0	$173,000	$0
Perinatal	$1,612,000	$27,000	$1,021,000	$0	$564,000
Mandatory					
Regular	$7,066,000	$3,500,000	$43,000	$0	$3,523,000
Minor Consent	$30,000	$0	$0	$30,000	$0
Perinatal	$280,000	$5,000	$177,000	$0	$98,000
Optional					
Regular	$19,937,000	$19,937,000	$0	$0	$0
Perinatal	$839,000	$839,000	$0	$0	$0
Total	$91,401,000	**$54,264,000**	**$2,255,000**	$10,482,000	**$24,400,000**

FY 2015-16	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Regular	$20,600,000	$10,203,000	$126,000	$10,271,000	$0
Perinatal	$1,129,000	$19,000	$715,000	$395,000	$0
Expanded					
Regular	$54,042,000	$26,767,000	$330,000	$0	$26,945,000
Minor Consent	$230,000	$0	$0	$230,000	$0
Perinatal	$2,160,000	$36,000	$1,368,000	$0	$756,000
Mandatory					
Regular	$9,972,000	$4,939,000	$61,000	$0	$4,972,000
Minor Consent	$42,000	$0	$0	$42,000	$0
Perinatal	$394,000	$7,000	$249,000	$0	$138,000
Optional					
Regular	$26,910,000	$26,910,000	$0	$0	$0
Perinatal	$1,116,000	$1,116,000	$0	$0	$0
Total	$116,595,000	**$69,997,000**	**$2,849,000**	$10,938,000	**$32,811,000**

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

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1728

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$72,494,000	$77,949,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$72,494,000	$77,949,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$72,494,000	$77,949,000

DESCRIPTION

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

Authority:
Title 22, California Code of Regulations 51341.1 (b)(17); 51341.1 (d)(1); 51516.1 (b)

Interdependent Policy Changes:
Not Applicable

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

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

With the provisions of the Affordable Care Act (ACA), the Department expects new Medi-Cal beneficiaries in the mandatory and optional population categories.

The mandatory expansion population refers to the population currently eligible but not enrolled in Medi-Cal. For this population's services, funding is 50% CF and 50% Title XIX FF. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

The optional expansion population was previously ineligible for Medi-Cal but became eligible starting January 1, 2014. Funding for this population's services is 100% Title XIX FF.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

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

Reason for Change from Prior Estimate:

- The Units of Service (UOS) were adjusted using the most current annual client caseload.
- The Department revised the ACA caseload projections based on updated enrollment data.

Methodology:

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

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

3. The caseload projections are based on 51 months of the most recent complete caseload data, January 2010 through March 2014.

4. Additional caseload data for the ACA eligibles was developed for the mandatory and optional populations.

5. Assume the caseload projection for the mandatory expansion population is 1,325 for FY 2014-15 and 1,428 for FY 2015-16.

6. Assume the caseload projection for the optional expansion population is 3,736 for FY 2014-15 and 3,793 for FY 2015-16.

7. The UOS is based on the most recent complete data, July 2012-June 2013 to calculate an average UOS.

8. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by Department of Finance, whichever is lower. FY 2014-15 and FY 2015-16 budgeted amounts are based on the FY 2014-15 rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

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

10. Amounts may differ due to rounding.

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

			FY 2014-15		FY 2015-16	
	UOS	Rates	Caseload	Total	Caseload	Total
Current Population						
Regular						
Dosing	263.1	$10.80	24,719	$70,239,000	25,796	$73,299,000
Individual	121.5	$13.48	24,719	$40,485,000	25,796	$42,249,000
Group	0.5	$2.91	24,719	$36,000	25,796	$38,000
Total				$110,760,000		$115,586,000
EPSDT						
Dosing	129.5	$10.80	310	$434,000	313	$438,000
Individual	69.0	$13.48	310	$288,000	313	$291,000
Group	0.0	$2.91	310	$0	313	$0
Total				$722,000		$729,000
Minor Consent						
Dosing	115.0	$10.80	-	$0	-	$0
Individual	103.9	$13.48	-	$0	-	$0
Group	0.0	$2.91	-	$0	-	$0
Total				$0		$0
Perinatal						
Dosing	111.8	$11.79	190	$250,000	202	$266,000
Individual	43.3	$21.06	190	$173,000	202	$184,000
Group	1.0	$7.03	190	$1,000	202	$1,000
Total				$424,000		$451,000
Mandatory						
Regular						
Dosing	263.1	$10.80	1,306	$3,711,000	1,408	$4,001,000
Individual	121.5	$13.48	1,306	$2,139,000	1,408	$2,306,000
Group	0.5	$2.91	1,306	$2,000	1,408	$2,000
Total				$5,852,000		$6,309,000
EPSDT						
Dosing	129.5	$10.80	12	$17,000	12	$17,000
Individual	69.0	$13.48	12	$11,000	12	$12,000
Group	0.0	$2.91	12	$0	12	$0
Total				$28,000		$29,000
Minor Consent						
Dosing	115.0	$10.80	-	$0	-	$0
Individual	103.9	$13.48	-	$0	-	$0
Group	0.0	$2.91	-	$0	-	$0
Total				$0		$0
Perinatal						
Dosing	111.8	$11.79	7	$9,000	8	$10,000
Individual	43.3	$21.06	7	$7,000	8	$7,000
Group	1.0	$7.03	7	$0	8	$0
Total				$16,000		$17,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

			FY 2014-15		FY 2015-16	
	UOS	Rates	Caseload	Total	Caseload	Total
Current Population						
Optional						
Regular						
Dosing	263.1	$10.80	3,685	$10,471,000	3,738	$10,622,000
Individual	121.5	$13.48	3,685	$6,035,000	3,738	$6,123,000
Group	0.5	$2.91	3,685	$5,000	3,738	$5,000
Total				$16,511,000		$16,750,000
EPSDT						
Dosing	129.5	$10.80	31	$44,000	34	$48,000
Individual	69.0	$13.48	31	$29,000	34	$32,000
Group	0.0	$2.91	31	$0	34	$0
Total						$80,000
Perinatal						
Dosing	111.8	$11.79	20	$26,000	21	$27,000
Individual	43.3	$21.06	20	$18,000	21	$19,000
Group	1.0	$7.03	20	$0	21	$0
Total				$44,000		$46,000
			TOTAL	$134,430,000		$139,997,000

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

Fiscal Year	Accrual	FY 2014-15	FY 2015-16
Regular	$124,494,000	$31,124,000	
Minor Consent	$93,000	$23,000	
Perinatal	$425,000	$106,000	
FY 2013-14	$125,012,000	$31,253,000	$0
Current			
Regular	$111,482,000	$83,611,500	$27,870,500
Minor Consent	$0	$0	$0
Perinatal	$424,000	$318,000	$106,000
Mandatory			
Regular	$5,880,000	$4,410,000	$1,470,000
Minor Consent	$0	$0	$0
Perinatal	$16,000	$12,000	$4,000
Optional			
Regular	$16,584,000	$12,438,000	$4,146,000
Perinatal	$44,000	$33,000	$11,000
FY 2014-15	$134,430,000	$100,822,500	$33,607,500
Current			
Regular	$116,315,000	$0	$87,236,250
Minor Consent	$0	$0	$0
Perinatal	$451,000	$0	$338,250

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

Fiscal Year	Accrual	FY 2014-15	FY 2015-16
Mandatory			
Regular	$6,338,000	$0	$4,753,500
Minor Consent	$0	$0	$0
Perinatal	$17,000	$0	$12,750
Optional			
Regular	$16,830,000	$0	$12,622,500
Perinatal	$46,000	$0	$34,500
FY 2015-16	$139,997,000	$0	$104,997,750
TOTAL		$132,075,500	$138,605,250

12. Newly eligible beneficiaries in the expanded and mandatory categories are funded 50% CF and 50% FF. Minor consent costs are funded by the counties. Beneficiaries in the optional category are funded 100% FF. A portion of children are funded 65% FF and 35% CF.

FY 2014-15	TF	FF (Title XIX)	FF (Title XXI)	County
Current				
Regular	$114,735,000	$56,828,000	$701,000	$57,206,000
Minor Consent	$23,000	$0	$0	$23,000
Perinatal	$423,000	$7,000	$268,000	$148,000
Mandatory				
Regular	$4,410,000	$2,184,000	$27,000	$2,199,000
Minor Consent	$0	$0	$0	$0
Perinatal	$12,000	$0	$8,000	$4,000
Optional				
Regular	$12,438,000	$12,438,000	$0	$0
Perinatal	$33,000	$33,000	$0	$0
Total	$132,074,000	**$71,490,000**	**$1,004,000**	$59,580,000

FY 2015-16	TF	FF (Title XIX)	FF (Title XXI)	County
Current				
Regular	$115,106,000	$57,012,000	$703,000	$57,391,000
Minor Consent	$0	$0	$0	$0
Perinatal	$443,000	$7,000	$281,000	$155,000
Mandatory				
Regular	$6,223,000	$3,082,000	$38,000	$3,103,000
Minor Consent	$0	$0	$0	$0
Perinatal	$17,000	$0	$11,000	$6,000
Optional				
Regular	$16,769,000	$16,769,000	$0	$0
Perinatal	$46,000	$46,000	$0	$0
Total	$138,604,000	**$76,916,000**	**$1,033,000**	$60,655,000

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

OUTPATIENT DRUG FREE TREATMENT SERVICES

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

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$33,512,000	$36,657,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$33,512,000	$36,657,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$33,512,000	$36,657,000

DESCRIPTION

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

Authority:
Title 22, California Code of Regulations 51341.1 (b)(18); 51341.1 (d)(2); 51516.1 (a)

Interdependent Policy Changes:
Not Applicable

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

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

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

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

With the provisions of the Affordable Care Act (ACA), the Department expects new Medi-Cal beneficiaries in mandatory and optional population categories.

The mandatory expansion population refers to the population currently eligible but not enrolled in Medi-Cal. Services for this population are funded with 50% CF and 50% Title XIX FF. Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

The optional expansion population was previously ineligible for Medi-Cal but became eligible starting January 1, 2014. Funding for this population's services is 100% Title XIX FF.

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

Reason for Change from Prior Estimate:

- The Department revised the ACA caseload projections based on enrollment data.
- The Units of Service (UOS) have been adjusted using the most current annual client caseload.

Methodology:

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

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

3. The caseload projections are based on 51 months of the most recent complete caseload data, January 2010 through March 2014.

4. The expansion of Medi-Cal eligibility impacts the caseload and projections for DMC. Additional caseload data for the expanded eligibles was developed for mandatory and optional populations due to the ACA.

5. Assume the caseload projection for the mandatory expansion population is 3,198 for FY 2014-15 and 3,448 for FY 2015-16.

6. Assume the caseload projection for the optional expansion population is 9,020 for FY 2014-15 and 9,158 for FY 2015-16.

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

8. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by DOF, whichever is lower. FY 2014-15 and FY 2015-16 budgeted amounts are based on the FY 2014-15 required rates. For more information about the FY 2014-15 rates, see the Annual Rate Adjustment policy change.

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

10. Amounts may contain rounding differences.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

			FY 2014-15		FY 2015-16	
	UOS	Rates	Caseload	Total	Caseload	Total
Current Population						
Regular						
Individual	5.5	$67.38	14,886	$5,517,000	14,118	$5,232,000
Group	57.5	$26.23	14,886	$22,451,000	14,118	$21,293,000
Subtotal				$27,968,000		$26,525,000
EPSDT						$0
Individual	5.5	$67.38	7,704	$2,855,000	7,926	$2,937,000
Group	29.1	$26.23	7,704	$5,880,000	7,926	$6,050,000
Subtotal				$8,735,000		$8,987,000
Minor Consent						$0
Individual	4.8	$67.38	4,118	$1,332,000	2,734	$884,000
Group	34.9	$26.23	4,118	$3,770,000	2,734	$2,503,000
Subtotal				$5,102,000		$3,387,000
Perinatal						$0
Individual	3.7	$105.32	517	$201,000	556	$217,000
Group	24.8	$63.33	517	$812,000	556	$873,000
Subtotal				$1,013,000	-	$1,090,000
Mandatory					-	$0
Regular					-	$0
Individual	5.5	$67.38	1,783	$661,000	1,922	$712,000
Group	57.5	$26.23	1,783	$2,689,000	1,922	$2,899,000
Subtotal				$3,350,000		$3,611,000
EPSDT						$0
Individual	5.5	$67.38	628	$233,000	677	$251,000
Group	29.1	$26.23	628	$480,000	677	$517,000
Subtotal				$713,000		$768,000
Minor Consent						$0
Individual	4.8	$67.38	762	$247,000	821	$265,000
Group	34.9	$26.23	762	$698,000	821	$751,000
Subtotal				$945,000		$1,016,000
Perinatal						$0
Individual	3.7	$105.32	25	$10,000	28	$11,000
Group	24.8	$63.33	25	$39,000	28	$43,000
Subtotal				$49,000		$54,000
Optional						$0
Regular						$0
Individual	5.5	$67.38	7,171	$2,658,000	7,290	$2,701,000
Group	57.5	$26.23	7,171	$10,816,000	7,290	$10,994,000
Subtotal				$13,474,000		$13,695,000
EPSDT						$0
Individual	5.5	$67.38	1,768	$655,000	1,795	$665,000
Group	29.1	$26.23	1,768	$1,350,000	1,795	$1,370,000
Subtotal				$2,005,000		$2,035,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

			FY 2014-15		FY 2015-16	
	UOS	Rates	Caseload	Total	Caseload	Total
Current Population						
Perinatal						$0
Individual	3.7	$105.32	81	$32,000	73	$29,000
Group	24.8	$63.33	81	$128,000	73	$115,000
Subtotal				$160,000		$144,000
Total				$63,514,000		$61,312,000

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

Fiscal Year	Accrual	FY 2014-15	FY 2015-16
Regular	$46,804,000	$11,701,000	$0
Minor Consent	$18,540,000	$4,635,000	$0
Perinatal	$411,000	$102,750	$0
FY 2013-14	$65,755,000	$16,438,750	$0
Current			
Regular	$36,703,000	$27,527,250	$9,175,750
Minor Consent	$5,102,000	$3,826,500	$1,275,500
Perinatal	$1,013,000	$759,750	$253,250
Mandatory			
Regular	$4,063,000	$3,047,250	$1,015,750
Minor Consent	$945,000	$708,750	$236,250
Perinatal	$49,000	$36,750	$12,250
Optional			
Regular	$15,479,000	$11,609,250	$3,869,750
Perinatal	$160,000	$120,000	$40,000
FY 2014-15	$63,514,000	$47,635,500	$15,878,500
Current			
Regular	$35,512,000	$0	$26,634,000
Minor Consent	$3,387,000	$0	$2,540,250
Perinatal	$1,090,000	$0	$817,500
Mandatory			
Regular	$4,379,000	$0	$3,284,250
Minor Consent	$1,016,000	$0	$762,000
Perinatal	$54,000	$0	$40,500
Optional			
Regular	$15,730,000	$0	$11,797,500
Perinatal	$144,000	$0	$108,000
FY 2015-16	$61,312,000	$0	$45,984,000
Total		$64,074,250	$61,862,500

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

12. Current beneficiaries and newly eligible beneficiaries in the mandatory categories are funded at 50% CF and 50% FF. Minor consent (MC) costs are funded by the counties. Beneficiaries in the optional category are funded 100% FF. A portion of children are funded 65% FF and 35% CF and the remaining children at 50% CF and 50% FF.

FY 2014-15	TF	FF (Title XIX)	FF (Title XXI)	County
Current				
Regular	$39,229,000	$19,430,000	$240,000	$19,559,000
Minor Consent	$8,462,000	$0	$0	$8,462,000
Perinatal	$863,000	$15,000	$546,000	$302,000
Expanded				
Regular	$0	$0	$0	$0
Minor Consent	$0	$0	$0	$0
Perinatal	$0	$0	$0	$0
Mandatory				
Regular	$3,047,000	$1,509,000	$19,000	$1,519,000
Minor Consent	$709,000	$0	$0	$709,000
Perinatal	$37,000	$1,000	$23,000	$13,000
Optional				
Regular	$11,609,000	$11,609,000	$0	$0
Perinatal	$120,000	$120,000	$0	$0
Total	$64,076,000	**$32,684,000**	**$828,000**	$30,564,000

FY 2015-16	TF	FF (Title XIX)	FF (Title XXI)	County
Current				
Regular	$35,810,000	$17,737,000	$219,000	$17,854,000
Minor Consent	$3,816,000	$0	$0	$3,816,000
Perinatal	$1,071,000	$18,000	$678,000	$375,000
Expanded				
Regular	$0	$0	$0	$0
Minor Consent	$0	$0	$0	$0
Perinatal	$0	$0	$0	$0
Mandatory				
Regular	$4,300,000	$2,130,000	$26,000	$2,144,000
Minor Consent	$998,000	$0	$0	$998,000
Perinatal	$52,000	$1,000	$33,000	$18,000
Optional				
Regular	$15,667,000	$15,667,000	$0	$0
Perinatal	$148,000	$148,000	$0	$0
Total	$ 61,862,000	**$ 35,701,000**	**$ 956,000**	$ 25,205,000

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

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1725

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$5,792,000	$63,887,000
- STATE FUNDS	$0	$19,610,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$5,792,000	$63,887,000
STATE FUNDS	$0	$19,610,000
FEDERAL FUNDS	$5,792,000	$44,277,000

DESCRIPTION

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

Authority:
Title 22, California Code of Regulations 51341.1 (b)(20); 51341.1 (d)(4); 51516.1 (a)

Interdependent Policy Changes:
Not Applicable

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

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

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

For FY 2014-15, the services are reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents. Room and board is not reimbursable through the Medi-Cal program.

The DMC program provides certain medically necessary substance use treatment services. These services are provided by certified providers under contract with the counties or with the State. Effective

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

July 1, 2011, the funds to cover the non-federal share of cost were realigned to counties as County Funds (CF). Funding for the services is 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65%.

Effective January 1, 2014, the Affordable Care Act (ACA) expanded Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The mandatory population resulted in a significant number of new Medi-Cal beneficiaries to receive DMC services.

A waiver to expanded Residential Treatment Services to non-perinatal beneficiaries is expected to be approved by July 1, 2015. In FY 2015-16, the Department expects to expand this service to the expanded, mandatory, and optional non-perinatal populations.

The mandatory expansion population refers to the population currently eligible but not enrolled in Medi-Cal. For this perinatal population's services, funding for the services is 50% CF and 50% Title XIX FF. Certain aid codes are eligible for Title XXI federal reimbursement at 65%. For the non-perinatal population, funding for the services is 50% General Funds (GF) and 50% Title XIX FF.

The expanded population refers to the population who is eligible and enrolled in Medi-Cal now, but is not receiving this service because it is currently not available to them. This population is expected to access this service starting July 1, 2015. Funding for the services is 50% GF and 50% Title XIX FFP.

The optional expansion population is currently not eligible for Medi-Cal but will become eligible for Medi-Cal starting January 1, 2014. This population is expected to access this service starting July 1, 2015. Funding for the service is 100% Title XIX FFP.

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

Reason for Change from Prior Estimate:
The estimate for May 2014 assumed the approval of a waiver to expand Residential Treatment services to non-perinatal beneficiaries. Since the waiver has not been approved yet, the FY 2014-15 estimate excludes the non-perinatal beneficiaries. In addition, the Department updated the ACA caseload projections.

Methodology:

1. For FY 2014-15, the DMC eligible clients are categorized as Perinatal. In FY 2015-16, the eligible clients are categorized as both Perinatal and Regular.

2. The caseload projections are based on 51 months of the most recent complete caseload data, January 2010 through March 2014.

3. Assume the caseload projection for the mandatory expansion population is 2,118 for FY 2014-15 and 2,283 for FY 2015-16 for the perinatal population.

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

5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2014-15 and FY 2015-16 budgeted amounts are based on the FY 2014-15 rates. For more information about the FY 2015-16 rates, see the Annual Rate Adjustment policy change.

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

7. Amounts may differ due to rounding.

FY 2014-15	Caseload	UOS	Rates	Total
Current				
Perinatal	270	62.6	$99.43	$1,681,000
Mandatory				
Perinatal	2,118	62.6	$99.43	$13,184,000
Total	2,388			$14,865,000

FY 2015-16	Caseload	UOS	Rates	Total
Current				
Perinatal	261	62.6	$99.43	$1,625,000
Mandatory				
Perinatal	2,283	62.6	$99.43	$14,212,000
Total	2,544			$15,837,000

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

Fiscal Year	Accrual	FY 2014-15	FY 2015-16
Perinatal	$1,388,000	$347,000	
FY 2013-14	$1,388,000	$347,000	$0
Current			
Perinatal	$1,681,000	$1,260,750	$420,250
Mandatory			
Perinatal	$13,184,000	$9,888,000	$3,296,000
FY 2014-15	$14,865,000	$11,148,750	$3,716,250
Current			
Perinatal	$1,625,000	$0	$1,218,750
Mandatory			
Perinatal	$14,212,000	$0	$10,659,000
FY 2015-16	$15,837,000	$0	$11,877,750
Total		$11,495,750	$15,594,000

9. Assume the non-perinatal population will be able to access the Residential Treatment Service effective July 1, 2015.

10. Assume the total number of beds available to the non-perinatal DMC beneficiaries seeking the Residential Treatment Service is 2,738.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

11. Assume 260 bed days are available at a service rate of $99.43. The bed days have been adjusted for holidays and weekends. Amounts may differ due to rounding.

    2,738 x 260 x $99.43 = $70,781,000 Annual expenditures for the non-perinatal population seeking Residential Treatment Services

12. In FY 2015-16, eight counties are expected to participate in providing the Residential Treatment Service to the non-perinatal population. Assume the 8 opt-in counties will begin to provide services effective July 1, 2015 with a six month phase-in. The counties will need time to build up a network and inform beneficiaries of the new service. Amounts may differ due to rounding.

    $70,781,000 x 79.17% = $56,029,000 (Cash basis)

13. Assume 60% of expenditures are for the expanded population receiving Residential Treatment Services. Funding for this population is 50% GF and 50% Title XIX FFP.

    $56,029,000 x 60% = $33,618,000 TF ($16,809,000 GF & $16,809,000 FF)

14. Assume 10% of expenditures are for the ACA Mandatory Expansion non-perinatal population receiving Residential Treatment Services. Funding for this population is 50% GF and 50% Title XIX FFP.

    $56,029,000 x 10% = $5,603,000 TF ($2,801,000 GF & $2,802,000 FF)

15. Assume 30% of expenditures are for the ACA Optional Expansion non-perinatal population receiving Residential Treatment Services. Funding is 100% FF.

    $56,029,000 x 30% = $16,809,000 FF

16. Funding for existing perinatal beneficiaries is 50% FF and 50% CF for both the current and mandatory population. Certain aid codes are eligible for Title XXI federal reimbursement at 65%. Newly eligible non-perinatal beneficiaries in the expanded and mandatory category are funded 50% FF and 50% GF. Beneficiaries in the optional category are funded 100% FFP.

FY 2014-15	TF	FF Title XIX	FF Title XXI	CF
Current				
Perinatal 50/50	$1,566,000	$783,000	$0	$783,000
Perinatal 65/35	$42,000	$0	$27,000	$15,000
Mandatory				
Perinatal 50/50	$9,632,000	$4,816,000	$0	$4,816,000
Perinatal 65/35	$256,000	$0	$166,000	$90,000
Total	$11,496,000	**$5,599,000**	**$193,000**	$5,704,000

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

FY 2015-16	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Perinatal 50/50	$1,596,000	$798,000	$0	$798,000	$0
Perinatal 65/35	$43,000	$0	$28,000	$15,000	$0
Expanded					
Regular	$33,618,000	$16,809,000	$0	$0	$16,809,000
Mandatory					
Regular	$5,603,000	$2,802,000	$0	$0	$2,801,000
Perinatal 50/50	$13,594,000	$6,797,000	$0	$6,797,000	$0
Perinatal 65/35	$362,000	$0	$235,000	$127,000	$0
Optional					
Regular	$16,809,000	$16,809,000	$0	$0	$0
Total	$71,625,000	**$44,014,000**	**$263,000**	$7,737,000	**$19,610,000**

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

PROVIDER FRAUD IMPACT TO DMC PROGRAM

BASE POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	8/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1828

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$27,850,000	-$27,850,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$27,850,000	-$27,850,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	-$27,850,000	-$27,850,000

DESCRIPTION

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

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

A statewide enforcement sweep was launched in July 2013. As of September 23, 2014, the Department has issued temporary suspensions for 229 sites out of the 1,568 certified DMC providers. In addition, the Department has lodged 93 Credible Allegations of Fraud with the California Department of Justice for potential prosecution. The billings from these temporarily suspended providers totaled $55.7 million of the $199.4 million in approved DMC billings for FY 2012-13.

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

PROVIDER FRAUD IMPACT TO DMC PROGRAM

BASE POLICY CHANGE NUMBER: 68

Methodology:

1. The FY 2014-15 and FY 2015-16 estimate is based on suspended DMC payments for FY 2012-13.

Cash Estimate	TF	FFP Title XIX	FFP Title XXI	CF
FY 2013-14	($55,700,000)	($27,293,000)	($557,000)	($27,850,000)
TOTAL FY 2014-15	($55,700,000)	**($27,293,000)**	**($557,000)**	($27,850,000)

Cash Estimate	TF	FFP Title XIX	FFP Title XXI	CF
FY 2014-15	($55,700,000)	($27,293,000)	($557,000)	($27,850,000)
TOTAL FY 2015-16	($55,700,000)	**($27,293,000)**	**($557,000)**	($27,850,000)

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

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1780

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,022,775,000	$1,145,028,000
- STATE FUNDS	$69,364,000	$71,820,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,022,775,000	$1,145,028,000
STATE FUNDS	$69,364,000	$71,820,000
FEDERAL FUNDS	$953,411,000	$1,073,208,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 69

The following Medi-Cal SMHS are available for adults:

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

Reason for Change from Prior Estimate:

- General Fund (GF) reimbursement authority has been included to account for the timing of the reimbursement from the county realignment funds to the Department.
- In the prior estimate, the optional population for SMHS for adults was included in the policy change titled ACA Optional Expansion. Now the optional population for SMHS for adults is included in this policy change.

Methodology:

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

2. Due to the lag in reporting of claims data, the six most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.

3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.

4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2012-13	$1,088,673	$946,078	$142,595
FY 2013-14	$1,131,245	$996,437	$134,808
FY 2014-15	$1,172,309	$1,032,460	$139,849
FY 2015-16	$1,213,371	$1,068,482	$144,889

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 69

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

(Dollars In Thousands)

	Total	FF	CF
FY 2012-13	$1,088,673	$544,337	$544,336
FY 2013-14	$1,131,245	$565,623	$565,622
FY 2014-15	$1,172,309	$586,155	$586,154
FY 2015-16	$1,213,371	$606,686	$606,685

6. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 21% of FY 2013-14 claims, and 78% of FY 2014-15 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2012-13 claims, 23% of FY 2013-14 claims, and 76% of FY 2014-15 claims. Amounts may contain rounding differences. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2012-13	$10,887	$9,461	$1,426
FY 2013-14	$240,062	$209,343	$30,719
FY 2014-15	$911,807	$805,224	$106,583
Total FY 2014-15	$1,162,756	$1,024,028	$138,728

7. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 claims, 21% of FY 2014-15 claims, and 78% of FY 2015-16 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2013-14 claims, 23% of FY 2014-15 claims, and 76% of FY 2015-16 claims. Amounts may contain rounding differences. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2013-14	$11,312	$9,964	$1,348
FY 2014-15	$248,778	$216,911	$31,867
FY 2015-16	$943,744	$833,320	$110,424
Total FY 2015-16	$1,203,834	$1,060,195	$143,639

8. Medi-Cal (MC) claims are eligible for 50% federal reimbursement. General Fund reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars In Thousands)

Cash Estimate	TF	FF	County	GF Reimbursement
Total FY 2014-15	$1,232,120	$581,378	$581,378	$69,364
Total FY 2015-16	$1,275,654	$601,917	$601,917	$71,820

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 69

9. Assume ACA impact to SMHS for Adults is $372,033,000 in FY 2014-15 and $471,291,000 in FY 2015-16 funded by 100% federal funds, on a cash basis.

(Dollars In Thousands)

Cash Estimate	TF	FF	County	GF Reimbursement
Total FY 2014-15	$1,604,153	**$953,411**	$581,378	**$69,364**
Total FY 2015-16	$1,746,945	**$1,073,208**	$601,917	**$71,820**

Funding:
100%Title XIX FFP (4260-101-0890)
100% Reimbursement (4260-601-0995)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1779

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$938,451,000	$990,486,000
- STATE FUNDS	$36,848,000	$39,354,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$938,451,000	$990,486,000
STATE FUNDS	$36,848,000	$39,354,000
FEDERAL FUNDS	$901,603,000	$951,132,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

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

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

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 70

The following Medi-Cal SMHS are available for children:

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

*Children - Age 18 through 20

Reason for Change from Prior Estimate:
Expenditures increased due to the inclusion of additional approved claims data.

Methodology:

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

2. 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. Therefore, the most recent six months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.

3. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2012-13	$1,565,139	$1,501,265	$63,874
FY 2013-14	$1,676,732	$1,604,688	$72,044
FY 2014-15	$1,767,004	$1,689,671	$77,333
FY 2015-16	$1,857,276	$1,774,653	$82,623

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 70

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

(Dollars In Thousands)

	TF	FF	CF
FY 2012-13	$1,565,139	$791,931	$773,208
FY 2013-14	$1,676,732	$863,018	$813,714
FY 2014-15	$1,767,004	$912,467	$854,537
FY 2015-16	$1,857,276	$961,916	$895,360

5. On a cash basis for FY 2014-15, the Department will be paying 1% of FY 2012-13 claims, 21% of FY 2013-14 claims, and 78% of FY 2014-15 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2012-13 claims, 23% of FY 2013-14 claims, and 76% of FY 2014-15 claims. Amounts may contain rounding differences. The overall cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2012-13	$15,652	$15,013	$639
FY 2013-14	$353,548	$337,131	$16,417
FY 2014-15	$1,376,727	$1,317,789	$58,938
Total FY 2014-15	$1,745,927	$1,669,933	$75,994

6. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 claims, 21% of FY 2014-15 claims, and 78% of FY 2015-16 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2013-14 claims, 23% of FY 2014-15 claims, and 76% of FY 2015-16 claims. Amounts may contain rounding differences. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2013-14	$16,767	$16,047	$720
FY 2014-15	$372,607	$354,985	$17,622
FY 2015-16	$1,447,038	$1,384,068	$62,970
Total FY 2015-16	$1,836,412	$1,755,100	$81,312

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 70

7. Medicaid Expansion Children's Health Insurance Program (M-CHIP) claims are eligible for federal reimbursement of 65%. Medi-Cal (MC) claims are eligible for 50% federal reimbursement. General Fund reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars In Thousands)

Cash Estimate	TF	FF	M-CHIP*	County	GF Reimbursement
Total FY 2014-15	$1,745,927	**$777,497**	**$124,106**	$844,324	**$36,848**
Total FY 2015-16	$1,836,412	**$808,455**	**$142,677**	$885,280	**$39,354**

Funding:
100% Title XIX FFP (4260-101-0890)
100% Title XXI FFP (4260-113-0890)*
100% Reimbursement (4260-601-0995)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER:	109
IMPLEMENTATION DATE:	7/2000
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	56

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$9,161,871,000	$9,425,937,000
- STATE FUNDS	$4,415,833,350	$4,547,770,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$9,161,871,000	$9,425,937,000
STATE FUNDS	$4,415,833,350	$4,547,770,800
FEDERAL FUNDS	$4,746,037,650	$4,878,166,200

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3

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

Reason for Change from Prior Estimate:
Rates and eligibles were updated. Non-specialty mental health and AB 97 costs were included in the baseline rates.

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

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 109

IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 118 Managed Care Rate Range IGTs.

3. Annual rate redeterminations include the following ongoing adjustments:
   - Annual rate redeterminations for FY 2014-15 and FY 2015-16.
   - LTC rate adjustments
   - Hospice rate increase
   - Elimination of inpatient hospital provider payment reduction
   - Inclusion of GHPP services
   - CBAS/Enhancement case management
   - Medicare improvements for Patients and Providers Act
   - Mental Health Increases
   - Transitioned SPD eligibles
   - Diagnosis Related Groups

4. New adjustments to the annual rate redeterminations include:
   - Blood factor drug carve-out

5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $253,900,000 for FY 2014-15 and $399,900,000 for FY 2015-16 were included in the rates.

6. The savings from AB 97 are included in the rates. Savings of $65,300,000 for FY 2014-15 and $50,900,000 for FY 2015-16 were included in the rates.

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

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

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

10. FY 2014-15 and 2015-16 costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 109

(Dollars in Thousands)

FY 2014-15	Eligible Months	Total
Alameda	2,472,290	$581,619
Contra Costa	1,547,498	$334,530
Kern	2,518,645	$397,717
Los Angeles	21,424,304	$3,638,019
Riverside	4,837,458	$792,626
San Bernardino	5,283,557	$868,242
San Francisco	1,070,052	$304,298
San Joaquin	2,005,839	$349,785
Santa Clara	2,554,096	$455,221
Stanislaus	1,497,896	$321,748
Tulare	1,791,106	$279,094
Fresno	3,318,539	$627,512
Kings	385,538	$64,877
Madera	473,634	$76,583
Total FY 2014-15	51,180,452	$9,091,871
Hepatitis C Adjustment		$70,000
Total with Adjustments		**$9,161,871**

(Dollars in Thousands)

Included in the Above Dollars	FY 2014-15
Mental Health	$253,900
Blood Factor	($10,100)
AB 97	($65,300)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 109

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Alameda	2,520,630	$597,754
Contra Costa	1,580,808	$345,033
Kern	2,566,210	$407,709
Los Angeles	21,705,060	$3,747,052
Riverside	4,942,044	$822,954
San Bernardino	5,432,710	$900,031
San Francisco	1,086,967	$312,407
San Joaquin	2,061,225	$362,051
Santa Clara	2,590,439	$465,671
Stanislaus	1,507,146	$323,518
Tulare	1,824,002	$286,681
Fresno	3,346,911	$639,636
Kings	392,297	$66,741
Madera	482,939	$78,699
Total FY 2015-16	52,039,388	$9,355,937
Hepatitis C Adjustment		$70,000
Total with Adjustments		**$9,425,937**

(Dollars in Thousands)

Included in the Above Dollars	FY 2015-16
Mental Health	$399,900
Blood Factor	($11,600)
AB 97	($50,900)

Funding:
(in Thousands)

FY 2014-15:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$8,327,683	$4,163,842	$4,163,842
State GF	4260-101-0001	$18,732	$18,732	$0
Family Planning 90/10 GF	4260-101-0001/0890	$208,599	$20,860	$187,739
Title XXI 65/35 GF	4260-113-0001/0890	$606,857	$212,400	$394,457
Total (rounded)		**$9,161,871**	**$4,415,834**	**$4,746,038**

FY 2015-16:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$8,590,215	$4,295,108	$4,295,108
State GF	4260-101-0001	$18,939	$18,939	$0
Family Planning 90/10 GF	4260-101-0001/0890	$208,599	$20,860	$187,739
Title XXI 65/35 GF	4260-113-0001/0890	$608,184	$212,864	$395,320
Total (rounded)		**$9,425,937**	**$4,547,771**	**$4,878,167**

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	12/1987
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	57

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$4,610,126,000	$4,652,444,000
- STATE FUNDS	$2,240,113,750	$2,260,055,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$4,610,126,000	$4,652,444,000
STATE FUNDS	$2,240,113,750	$2,260,055,300
FEDERAL FUNDS	$2,370,012,250	$2,392,388,700

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3

Interdependent Policy Changes:
PC 124 Managed Care Expansion to Rural Counties
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:
A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 22 counties in the COHS Model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

Reason for Change from Prior Estimate:
Rates and eligibles were updated. Non-specialty mental health and AB 97 costs were included in the baseline rates.

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

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 111

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 118 Managed Care Rate Range IGTs.

3. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA). PHC is negotiating with the Department to remove OBRA beneficiaries from their contract effective January 1, 2013.

4. Annual rate redeterminations include the following ongoing adjustments:
   - Annual rate redeterminations for FY 2014-15 and FY 2015-16.
   - LTC rate adjustments
   - Hospice rate increase
   - Elimination of inpatient hospital provider payment reduction
   - Inclusion of GHPP services
   - CBAS/Enhancement case management
   - Medicare improvements for Patients and Providers Act
   - Mental Health Increases
   - Transitioned SPD eligibles
   - Diagnosis Related Groups

5. New adjustments to the annual rate redeterminations include:
   - Blood factor drug carve-out

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

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

8. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $66,500,000 for FY 2014-15 and $105,100,000 for FY 2015-16 were included in the rates.

9. The savings from AB 97 are included in the rates. Savings of $14,630,000 for FY 2014-15 and $11,411,000 for FY 2015-16 were included in the rates.

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

11. FY 2014-15 and 2015-16 costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 111

(Dollars in Thousands) **FY 2014-15**	**Eligible Months**	**Total**
San Luis Obispo	447,011	$111,336
Santa Barbara	988,002	$249,235
San Mateo	952,922	$325,642
Solano	927,244	$287,247
Santa Cruz	545,575	$142,824
CalOPTIMA(Orange)	6,205,409	$1,487,839
Napa	242,321	$72,083
Monterey	1,255,301	$273,099
Yolo	423,085	$129,782
Sonoma	906,904	$262,050
Merced	1,090,551	$216,017
Marin	281,786	$101,185
Mendocino	291,539	$73,473
Ventura	1,601,694	$363,131
Del Norte	98,507	$30,324
Humboldt	364,728	$119,908
Lake	234,427	$75,476
Lassen	61,031	$19,730
Modoc	25,156	$10,510
Shasta	523,648	$184,822
Siskiyou	135,558	$41,463
Trinity	35,205	$11,950
Total FY 2014-15	17,637,604	$4,589,126
Hepatitis C Adjustment		$21,000
Total with Adjustments		**$4,610,126**

(Dollars in Thousands) Included in Above Dollars	**FY 2014-15**
Mental Health	$66,500
Blood Factor	($21,300)
AB 97	($14,630)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 111

(Dollars in Thousands) **FY 2015-16**	**Eligible Months**	**Total**
San Luis Obispo	451,867	$112,141
Santa Barbara	995,659	$250,911
San Mateo	970,156	$329,896
Solano	939,318	$291,625
Santa Cruz	547,232	$143,517
CalOPTIMA (Orange)	6,269,303	$1,506,193
Napa	248,733	$73,824
Monterey	1,270,998	$276,309
Yolo	429,133	$131,207
Sonoma	924,791	$265,184
Merced	1,101,380	$217,779
Marin	283,603	$101,586
Mendocino	293,097	$73,718
Ventura	1,601,410	$363,051
Del Norte	98,514	$30,338
Humboldt	365,097	$119,975
Lake	235,005	$75,585
Lassen	61,458	$19,814
Modoc	25,351	$10,558
Shasta	523,489	$184,773
Siskiyou	135,666	$41,488
Trinity	35,231	$11,972
Total FY 2015-16	17,806,491	$4,631,444
Hepatitis C Adjustment		$21,000
Total with Adjustments		**$4,652,444**

(Dollars in Thousands) Included in Above Dollars	**FY 2015-16**
Mental Health	$105,100
Blood Factor	($24,500)
AB 97	($11,411)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 111

Funding:
(Dollars in Thousands)

FY 2013-14:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$4,221,522	$2,110,761	$2,110,761
State GF	4260-101-0001	$4,884	$4,884	$0
Family Planning 90/10 GF	4260-101-0001/0890	$39,333	$3,933	$35,400
Title XXI 65/35 GF	4260-113-0001/0890	$344,387	$120,535	$223,852
Total		**$4,610,126**	**$2,240,113**	**$2,370,013**

FY 2014-15:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$4,257,925	$2,128,963	$2,128,963
State GF	4260-101-0001	$4,916	$4,916	$0
Family Planning 90/10 GF	4260-101-0001/0890	$40,737	$4,074	$36,663
Title XXI 65/35 GF	4260-113-0001/0890	$348,866	$122,103	$226,763
Total		**$4,652,444**	**$2,260,056**	**$2,392,389**

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER:	112
IMPLEMENTATION DATE:	4/1994
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	58

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,769,845,000	$1,819,186,000
- STATE FUNDS	$857,215,100	$881,375,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,769,845,000	$1,819,186,000
STATE FUNDS	$857,215,100	$881,375,500
FEDERAL FUNDS	$912,629,900	$937,810,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3

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

Reason for Change from Prior Estimate:
Rates and eligibles were updated. Non-specialty mental health and AB 97 costs were included in the baseline rates.

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

2. The GMC program requires mandatory enrollment for most of Public Assistance, Medically Needy, Medically Indigent Children, Refugee beneficiaries, and Poverty aid codes.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 112

3. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 118 Managed Care Rate Range IGTs.

4. Annual rate redeterminations include the following ongoing adjustments:
    - Annual rate redeterminations for FY 2014-15 and FY 2015-16.
    - LTC rate adjustments
    - Hospice rate increase
    - Elimination of inpatient hospital provider payment reduction
    - Inclusion of GHPP services
    - CBAS/Enhancement case management
    - Medicare improvements for Patients and Providers Act
    - Mental Health Increases
    - Transitioned SPD eligibles
    - Diagnosis Related Groups

5. New adjustments to the annual rate redeterminations include:
    - Blood factor drug carve-out

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

7. Capitation rate increases due to MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.

8. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $35,400,000 for FY 2014-15 and $55,300,000 for FY 2015-16 were included in the rates.

9. The savings from AB 97 are included in the rates. Savings of $12,000,000 for FY 2014-15 and $9,400,000 for FY 2015-16 were included in the rates

10. The FY 2014-15 and FY 2015-16 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

11. FY 2014-15 and 2015-16 costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 112

(Dollars in Thousands)

FY 2014-15	Eligible Months	Total
Sacramento GMC	3,511,071	$739,468
San Diego GMC	4,762,358	$1,019,377
Total FY 2014-15	8,273,429	$1,758,845
Hepatitis C Adjustment		$11,000
Total with Adjustments		**$1,769,845**

(Dollars in Thousands)

Included in the Above Dollars	FY 2014-15
Mental Health	$35,400
Blood Factor	($1,800)
AB 97	($12,000)

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Sacramento GMC	3,545,504	$751,037
San Diego GMC	4,882,162	$1,057,149
Total FY 2015-16	8,427,666	$1,808,186
Hepatitis C Adjustment		$11,000
Total with Adjustments		**$1,819,186**

(Dollars in Thousands)

Included in the Above Dollars	FY 2015-16
Mental Health	$55,300
Blood Factor	($2,000)
AB 97	($9,400)

Funding:

(Dollars in Thousands)

FY 2014-15:		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$1,608,832	$804,416	$ 804,416
State GF	4260-101-0001	$ 2,907	$ 2,907	$ 0
Family Planning 90/10 FFP	4260-101-0001/0890	$ 21,780	$ 2,178	$ 19,602
Title XXI 65/35 FFP	4260-113-0001/0890	$ 136,326	$ 47,714	$ 88,612
Total		**$1,769,845**	**$857,215**	**$ 912,630**

FY 2015-16:		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$1,655,914	$827,957	$ 827,957
State GF	4260-101-0001	$ 2,943	$ 2,943	$ 0
Family Planning 90/10 FFP	4260-101-0001/0890	$ 22,558	$ 2,256	$ 20,302
Title XXI 65/35 FFP	4260-113-0001-0890	$ 137,772	$ 48,220	$ 89,552
Total		**$1,819,186**	**$881,376**	**$ 937,811**

REGIONAL MODEL

BASE POLICY CHANGE NUMBER:	116
IMPLEMENTATION DATE:	11/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1842

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$388,003,000	$388,228,000
- STATE FUNDS	$185,242,050	$184,337,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$388,003,000	$388,228,000
STATE FUNDS	$185,242,050	$184,337,950
FEDERAL FUNDS	$202,760,950	$203,890,050

DESCRIPTION

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

Authority:
AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:
PC 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 coordinated their care and leads to better health outcomes and lower costs.

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

Reason for Change from Prior Estimate:
Updated rates and eligibles. Inclusion of SPDs who opted to enroll during the previous fiscal year. These SPDs were previously in PC 127 Managed Care Expansion to Rural Counties, but they are now in the base.

Methodology:
1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rebasing process includes refreshed data and adjustments to trends.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 116

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

3. Capitation rate increases due to MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.

4. Annual rate redeterminations include the following ongoing adjustments:
    - Annual rate redeterminations for FY 2014-15
    - LTC rate adjustments
    - Hospice rate increase
    - CBAS carved-in as of December 1, 2014
    - Mandatory enrollment for GMC programs as of December 1, 2014
    - Mental Health Increases

5. New adjustments to the annual rate redeterminations include:
    - Blood factor drug carve-out

6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of $20,900,000 for FY 2014-15 and $34,800,000 for FY 2015-16 were included in the rates.

7. The savings from AB 97 are included in the rates. Savings of $3,700,000 for FY 2014-15 and $3,200,000 for FY 2015-16 were included in the rates.

8. The FY 2014-15 and FY 2015-16 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.

9. FY 2014-15 and 2015-16 costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes.

10. Effective December 1, 2014, all non-dual Seniors and Persons with Disabilities (SPDs) will be required to enroll. The SPD population is shown in PC 127 Expand Managed Care to Rural Counties.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 116

(Dollars in Thousands)

FY 2014-15	Eligible Months	Total
Alpine	1,563	$227
Amador	40,639	$6,072
Butte	433,317	$68,632
Calaveras	58,864	$8,772
Colusa	54,314	$7,627
El Dorado	179,657	$26,829
Glenn	71,499	$10,580
Inyo	29,944	$4,789
Mariposa	25,259	$3,919
Mono	16,260	$2,357
Nevada	114,265	$16,952
Placer	298,511	$43,999
Plumas	25,450	$3,978
Sierra	3,894	$584
Sutter	232,437	$33,580
Tehama	153,571	$23,302
Tuolumne	72,073	$11,273
Yuba	172,839	$25,912
Imperial	550,918	$75,845
San Benito	69,081	$9,074
Total FY 2014-15	2,604,355	$384,303
Hepatitis C Adjustment		$3,700
Total with Adjustments		**$388,003**

(Dollars in Thousands)

Included in the Above Dollars	FY 2014-15
Mental Health	$20,900
Blood Factor	($4,000)
AB 97	($3,700)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 116

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Alpine	1,554	$226
Amador	40,633	$6,071
Butte	434,170	$68,741
Calaveras	58,897	$8,775
Colusa	54,256	$7,617
El Dorado	179,741	$26,833
Glenn	71,526	$10,583
Inyo	29,992	$4,794
Mariposa	25,259	$3,921
Mono	16,272	$2,358
Nevada	114,281	$16,954
Placer	299,074	$44,063
Plumas	25,487	$3,984
Sierra	3,906	$585
Sutter	232,325	$33,555
Tehama	153,913	$23,345
Tuolumne	72,025	$11,263
Yuba	172,659	$25,885
Imperial	551,337	$75,897
San Benito	69,115	$9,078
Total FY 2015-16	2,606,422	$384,528
Hepatitis C Adjustment		$3,700
Total with Adjustments		**$388,228**

(Dollars in Thousands)

Included in the Above Dollars	FY 2015-16
Mental Health	$34,800
Blood Factor	($5,800)
AB 97	($3,200)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 116

Funding:

(Dollars in Thousands)

FY 2014-15

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$337,673	$168,837	$168,837
State GF	4260-101-0001	$1,087	$1,087	$0
Family Planning 90/10 GF	4260-101-0001/0890	$7,666	$767	$6,899
Title XXI 65/35 GF	4260-113-0001/0890	$41,577	$14,552	$27,025
Total		**$388,003**	**$185,243**	**$202,761**

FY 2015-16		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	$331,573	$165,787	$165,787
State GF	4260-101-0001	$1,088	$1,088	$0
Family Planning 90/10 GF	4260-101-0001/0890	$7,940	$794	$7,146
Title XXI 65/35 GF	4260-113-0001/0890	$47,627	$16,669	$30,958
Total		**$388,228**	**$184,338**	**$203,891**

PACE (Other M/C)

BASE POLICY CHANGE NUMBER:	119
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	62

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$242,264,000	$315,767,000
- STATE FUNDS	$121,132,000	$157,883,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$242,264,000	$315,767,000
STATE FUNDS	$121,132,000	$157,883,500
FEDERAL FUNDS	$121,132,000	$157,883,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14591-14593
Balanced Budget Act of 1997 (BBA)
SB 870 (Chapter 40, Statutes 2014)

Interdependent Policy Changes:
Not Applicable

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

The Department currently has eight contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. Three new PACE organizations will begin operations in FY 2014-15. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits (UPL). Pursuant to SB 870, effective April 1, 2015, rates are set at no less than 95% of the FFS Upper Payment Limits (UPL). PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

Reason for Change from Prior Estimate:
The UPL increased but was offset by a decrease in enrollment projections.

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 119

Below is a list of PACE organizations:

PACE Organization	County	Operational
On Lok Lifeways	San Francisco Alameda Santa Clara	November 1, 1983 July 1, 2002 January 1, 2009
Centers for Elders' Independence	Alameda	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino Riverside	April 1, 2014 January 1, 2015
Central Valley Medical Svs.	Fresno	August 1, 2014
Redwood Coast	Humboldt	September 1, 2014
San Ysidro	San Diego	January 1, 2015

Methodology:

1. Assume the 2014 and 2015 rates are calculated using the UPL for each year. The 2016 rates will be calculated using the existing comparable population UPL methodology.

2. FY 2014-15 and FY 2015-16 estimated funding is based on approved calendar year (CY) 2014 rates and projected CY 2015 rates and CY 2016 rates.

3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan and anticipated impact of the CCI demonstration.

4. The Department is working with PACE organizations and proposing changes to current law to transition from a UPL-based methodology to an actuarially sound experienced-based methodology. The Department anticipates restructuring the methodology to determine the rates beginning in January 2016.

5. The Department received CMS approval of contract change orders to implement 2013 PACE rates, retroactive to January 2013, in August 2014. This will result in a repayment to PACE organizations of approximately $4,182,000 for the increase of Medi-Cal Only and Dual rates that were paid at 2012 rates. This repayment is expected to occur during the October 2014 capitation cycle. The Department anticipates receiving the Centers for Medicare and Medicaid Services' (CMS) approval of contract amendments implementing 2014 PACE rates, retroactive

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 119

to January 2014, in October 2014. This results in a repayment to PACE organizations of approximately $6,024,000 for the increase of Medi-Cal Only and Dual rates that were paid at 2013 PACE rates. The repayment is expected to occur during the December 2014 capitation cycle.

The Department will also recoup approximately $11,658,000 for the decrease of Medi-Cal Only and Dual rates that were paid at 2012 rates. The recoupment will begin with the October 2014 capitation cycle and is expected to be completed by the September 2015 capitation cycle.

6. The Department anticipates receiving CMS approval of contract amendments implementing 2014 PACE rates, retroactive to January 2014, in October 2014. This results in a recoupment of approximately $47,000 for the decrease of Medi-Cal Only and Dual rates that were paid at 2013 PACE rates. This recoupment is expected to occur during the December 2014 capitation cycle.

FY 2014-15	**Cost (Rounded)**	**Eligible Months**	**Avg. Monthly Enrollment**
Centers for Elders' Independence	$37,024,000	8,546	712
Sutter Senior Care	$13,768,000	3,336	278
AltaMed Senior BuenaCare	$76,627,000	20,010	1,668
OnLok (SF, Alameda and Santa Clara)	$74,387,000	16,338	1,362
St. Paul's PACE	$22,098,000	5,562	464
Los Angeles Jewish Homes	$5,500,000	1,566	131
CalOptima PACE	$2,941,000	798	67
InnovAge (San Bernardino and Riverside)	$4,161,000	996	83
Redwood Coast	$1,017,000	286	24
Central Valley Medical Services	$2,730,000	684	57
San Ysidro San Diego	$596,000	150	13
Total Capitation Payments	$240,849,000	58,272	4,859
2013 Rate Repayment	$4,182,000		
2014 Rate Repayment	$6,024,000		
2013 Rate Recoupment	($8,744,000)		
2014 Rate Recoupment	($47,000)		
Total FY 2014-15	**$242,264,000**		

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 119

FY 2015-16	Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence	$56,077,000	12,157	1,013
Sutter Senior Care	$16,256,000	3,679	307
AltaMed Senior BuenaCare	$86,147,000	21,263	1,772
OnLok (SF, Alameda and Santa Clara)	$90,560,000	18,933	1,578
St. Paul's PACE	$30,532,000	7,520	627
Los Angeles Jewish Homes	$8,867,000	2,393	199
CalOptima PACE	$5,918,000	1,518	127
InnovAge (San Bernardino and Riverside)	$9,159,000	2,167	181
Redwood Coast	$2,677,000	740	62
Central Valley Medical Services	$7,770,000	1,894	158
San Ysidro San Diego	$4,719,000	1,171	98
Total Capitation Payments	$318,682,000	73,435	6,122
2013 Rate Recoupment	($2,915,000)		
Total FY 2015-16	**$315,767,000**		

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

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER:	120
IMPLEMENTATION DATE:	7/2004
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1029

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$102,736,000	$103,902,000
- STATE FUNDS	$51,368,000	$51,951,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$102,736,000	$103,902,000
STATE FUNDS	$51,368,000	$51,951,000
FEDERAL FUNDS	$51,368,000	$51,951,000

DESCRIPTION

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

Authority:
Social Security Act, Title XIX
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:
Not Applicable

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

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

AB 82 restores partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services that can be offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including FQHCs and RHCs, will be limited to the adult optional benefits being restored May 1, 2014, in addition to the current scope of adult dental benefits which include services for pregnant women, emergency services, FRADs, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. The impact of the restoration of adult dental benefits is included in the capitation rates.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 120

Reason for Change from Prior Estimate:
The changes are due to updated rates and monthly eligibles. In addition, the rates include the impact of implementing the change to the $1,800 soft cap and Restoration of Select Adult Dental Benefits.

Methodology:

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.

2. The retroactive adjustments of the rates from January 2013 to June 2014 are shown in the Dental Retroactive Rate Changes policy change.

3. Dental rates for the Senior Care Action Network (SCAN) and the Program of All-Inclusive Care for the Elderly (PACE) are incorporated into the SCAN and PACE policy changes.

4. Rate adjustments have been included for FY 2014-15. These rates have been used for FY 2015-16.

5. For FY 2014-15 and FY 2015-16, the impact of the Restoration of Adult Dental Benefits are included.

6. For FY 2014-15 and FY 2015-16, the impact of AB 97 is incorporated into the AB 97 policy change.

7. The capitation rates include the impact of implementing the change to $1,800 soft cap. For FY 2014-15 and FY 2015-16, the impact is $90,000 per fiscal year.

(Dollars in Thousands) **FY 2014-15**	**Capitation Rate**	**Average Monthly Eligibles**	**Total Funds**
GMC			
<21	$12.13	200,609	$29,201
21+	$8.50	115,149	$11,745
PHP			
<21	$13.73	304,325	$50,141
21+	$7.88	123,187	$11,649
			$102,736
Restoration of Select Adult Dental Benefits (included in above dollars)			
GMC	$6.46	115,149	$8,926
PHP	$6.46	123,187	$9,549
			$18,475
$1,800 Soft Cap (included in above dollars)			$90

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 120

FY 2015-16	Capitation Rates	Monthly Eligibles	Total Funds
GMC			
<21	$12.13	206,570	$30,068
21+	$8.50	118,571	$12,094
PHP			
<21	$13.73	304,082	$50,101
21+	$7.88	123,088	$11,639
			$103,902
Restoration of Select Adult Dental Benefits (included in above dollars)			
GMC	$5.84	118,571	$8,309
PHP	$5.84	123,088	$8,626
			$16,935
$1,800 Soft Cap (included in above dollars)			$90

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

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER:	121
IMPLEMENTATION DATE:	2/1985
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	61

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$44,222,000	$43,997,000
- STATE FUNDS	$22,111,000	$21,998,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$44,222,000	$43,997,000
STATE FUNDS	$22,111,000	$21,998,500
FEDERAL FUNDS	$22,111,000	$21,998,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14200

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

Reason for Change from Prior Estimate:
The estimated costs have changed resulting from final CMS approval of the FY 2012-13 and 2014 SCAN rates, which delayed the recoupment and repayment of capitation payments.

Methodology:
1. Estimated SCAN costs are computed by multiplying the actual and estimated monthly eligible count for each county by the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.

2. Total enrollment is projected to be 8,378 in December 2014 and 8,700 by June 2015 based on Medi-

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 121

Cal enrollment projections submitted by SCAN.

3. The FY 2012-13 and 2014 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for CY 2015 and 2016 have not been finalized. The Department used an estimated CY 2015 rate trended forward from CY 2014 rates. Rates in development will be based on SCAN plans' actual experience.

4. AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the Gross Premium Tax through June 30, 2012. SB 78 extended the 2.35% Gross Premium Tax through June 30, 2013. SB 78 also applied the 3.9375% statewide sales tax to Medi-Cal Managed Care plans effective July 1, 2013, through July 1, 2016.

5. The Department received final CMS approval of contract amendment to implement the recalculated SCAN rates for the period of July 2013 through December 2013. This will result in a repayment to SCAN of approximately $305,000 for the increase of Aged/Disabled and LTC SCAN rates. The repayment is expected to occur in September 2014.

6. The Department received final CMS approval of contract amendment to implement CY 2014 SCAN rates, retroactive to January 2014. This will result in a repayment to SCAN of approximately $1,627,000 for capitation payment made between January through August 2014 using the SCAN FY 2012-13 rates. The repayment is expected to occur in September 2014.

FY 2014-15		**Costs**	**Eligible Months**	**Avg. Monthly Enrollment**
Los Angeles		$28,182,000	65,926	5,494
Riverside		$8,125,000	21,474	1,789
San Bernardino		$5,983,000	13,940	1,162
	Total	$42,290,000	101,340	8,445
2013 Rate Repayment		$305,000		
2014 Rate Repayment		$1,627,000		
	Total FY 2014-15	**$44,222,000**		
FY 2015-16				
Los Angeles		$28,972,000	66,678	5,557
Riverside		$8,531,000	23,644	1,970
San Bernardino		$6,494,000	15,597	1,300
	Total	**$43,997,000**	105,919	8,827

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

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER:	125
IMPLEMENTATION DATE:	5/1985
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	63

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$8,171,000	$7,003,000
- STATE FUNDS	$4,085,500	$3,501,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$8,171,000	$7,003,000
STATE FUNDS	$4,085,500	$3,501,500
FEDERAL FUNDS	$4,085,500	$3,501,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14088.85

Interdependent Policy Changes:
PC 131 Extend Gross Premium Tax
PC 123 Extend Gross Premium Tax – Incr. Capitation Rates
PC 122 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 HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with AIDS Healthcare Centers as a PCCM plan and participates in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department has determined that there are no shared savings for calendar year (CY) 2009. The shared savings for CY 2010, CY 2011, CY 2012 and beyond have not yet been determined. The Department entered into a new five year contract with AIDS Healthcare Foundation effective January 1, 2012, through December 31, 2016.

The PCCM received capitation payments at the 2011 capitation rates throughout 2012 as well as 2013. This has resulted in an overpayment to the PCCM given a reduction in capitation rates in 2012 and 2013 relative to 2011. The Department has a contractual option to recoup the overpayment on a monthly basis, retroactive to January 2012. Recoupment is expected to being January 2015.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 125

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

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

Reason for Change from Prior Estimate:
Updated rates and a delay of the recoupment of retroactive rate adjustments.

Methodology:

1. Assume dual eligible months will be 4,200 in FY 2014-15 and FY 2015-16.

2. Assume Medi-Cal only eligible months will be 5,400 in FY 2014-15 and FY 2015-16.

3. Dual capitation rates are assumed to be $292.07 for FY 2014-15 and FY 2015-16.

4. Medi-Cal only capitation rates are assumed to be $1,502.07 for FY 2014-15 and FY 2015-16.

   Duals:
   FY 14-15: 4,200 x $292.07 = $1,227,000
   FY 15-16: 4,200 x $292.07 = $1,227,000

   Medi-Cal Only:
   FY 14-15: 5,400 x $1,502.07 = $8,111,000
   FY 15-16: 5,400 x $1,502.07 = $8,111,000

5. The total recoupment for calendar years 2012 and 2013 is estimated to be $1,167,000 in FY 2014-15 and $2,335,000 in FY 2015-16.

	FY 2014-15	FY 2015-16
Dual	$1,227,000	$1,227,000
Medi-Cal Only	$8,111,000	$8,111,000
Recoupment	-$1,167,000	-$2,335,000
Total	**$8,171,000**	**$7,003,000**

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

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

BASE POLICY CHANGE NUMBER:	127
IMPLEMENTATION DATE:	7/2012
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	66

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,065,000	$1,065,000
- STATE FUNDS	$532,500	$532,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,065,000	$1,065,000
STATE FUNDS	$532,500	$532,500
FEDERAL FUNDS	$532,500	$532,500

DESCRIPTION

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

Authority:
Welfare & Institutions Code 14087.3

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

Reason for Change from Previous Estimate:
The contract with the Family Mosaic project was extended from July 1, 2014, through June 30, 2015. The Department anticipates continuing this agreement with Family Mosaic. The estimated number of member months has dropped as a result of the previous assumption of the contract ending.

Methodology:
1. Assume the member months will be 576 for FY 2014-15 and 576 for FY 2015-16.

2. The Family Mosaic capitation rates are assumed to be $1,848.75 for both FY 2014-15 and FY 2015-16.

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

BASE POLICY CHANGE NUMBER: 127

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

   FY 2014-15: 576 x $1,848.75 = **$1,065,000 TF ($532,000 GF)**

   FY 2015-16: 576 x $1,848.75 = **$1,065,000 TF ($532,000 GF)**

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	167
IMPLEMENTATION DATE:	4/1993
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	22

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$3,261,974,000	$3,417,045,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,261,974,000	$3,417,045,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,261,974,000	$3,417,045,000

DESCRIPTION

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

Authority:
Interagency Agreements:
03-75676 (PCSP)
09-86307 (IPO)
SB 1036 (Chapter 45, Statutes of 2012)
SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

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

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

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

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 167

Reason for Change from Prior Estimate:
Updated expenditure data received from CDSS.

Methodology:
1) The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

	TF	FFP	CDSS GF/ County Share
FY 2014-15	$6,523,948	**$3,261,974**	$3,261,974
FY 2015-16	$6,826,877	**$3,417,045**	$3,409,832

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

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

BASE POLICY CHANGE NUMBER:	168
IMPLEMENTATION DATE:	7/1988
ANALYST:	Humei Wang
FISCAL REFERENCE NUMBER:	76

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,598,884,000	$2,637,307,000
- STATE FUNDS	$1,393,496,500	$1,415,148,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,598,884,000	$2,637,307,000
STATE FUNDS	$1,393,496,500	$1,415,148,000
FEDERAL FUNDS	$1,205,387,500	$1,222,159,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
The Medicare 2015 premiums were released and 2016 estimated premiums have been adjusted accordingly. Previous estimate and this estimate's premiums and Average Monthly Eligibles are shown below with actual premiums:

	2014	2015		2016
	Actual	May 2014 Estimate	November 2014 Estimate	November 2014 Estimate
	Premiums			
Part A	$ 426.00	$ 441.00	$ 407.00	$ 407.00
Part B	$ 104.90	$ 110.20	$ 104.90	$ 104.90
	Average Monthly Eligibles			
Part A		177,500	177,000	179,900
Part B		1,234,400	1,292,500	1,329,500

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

BASE POLICY CHANGE NUMBER: 168

Methodology:

1. This policy change also includes adjustments due to reconciliations of state and federal data.

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

3. The Centers for Medicare and Medicaid set the 2015 Medicare Part A premium at $407.00 and the Medicare Part B premium at $104.90.

4. The 2016 Medicare Part A premium is estimated to remain at $407.00 and the Medicare Part B premium is estimated to remain at $104.90.

5. This estimate includes a credit adjustment of approximately $59 million TF ($29.5 million GF) resulting from a CMS reconciliation in July 2014.

FY 2014-15	**Part A**	**Part B**
Average Monthly Eligibles	177,000	1,292,500
Rate 07/2014-12/2014	$426.00	$104.90
Rate 01/2015-06/2015	$407.00	$104.90
FY 2015-16		
Average Monthly Eligibles	179,900	1,329,500
Rate 07/2015-12/2015	$407.00	$104.90
Rate 01/2016-06/2016	$407.00	$104.90

Funding:

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

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER:	169
IMPLEMENTATION DATE:	1/2006
ANALYST:	Peter Bjorkman
FISCAL REFERENCE NUMBER:	1019

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,537,016,000	$1,641,475,000
- STATE FUNDS	$1,537,016,000	$1,641,475,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,537,016,000	$1,641,475,000
STATE FUNDS	$1,537,016,000	$1,641,475,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreases by 1 ⅔% each year until it reaches 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 169

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

Calendar Year	PMPM rate
2012	$102.76
2013	$103.70
2014	$97.40
2015	$99.13 (estimated)
2016	$103.17 (estimated)

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

Fiscal Year	Total Payment	Ave.Monthly Beneficiaries
FY 2011-12	$1,367,279,250	1,150,028
FY 2012-13	$1,454,929,918	1,176,313
FY 2013-14	$1,479,580,071	1,213,682

Reason for Change from Prior Estimate:

Part D enrollment has increased steadily since the first quarter of 2014.

Methodology:

1. The 2014 growth decreased 4.03% and Medi-Cal's estimated PMPM decreased to $97.40.

2. The 2015 growth is estimated to increase 4.02% based on the adjusted 2014 estimated growth change from *Centers for Medicare & Medicaid Services.* Medi-Cal's estimated PMPM is $99.13.

3. The 2016 growth is estimated to increase 4.07% based on the adjusted 2015 estimated growth change from *Centers for Medicare & Medicaid Services.* Medi-Cal's estimated PMPM is $103.17.

4. Phase-down payments have a two-month lag (i.e., bills submitted in January are received in February and due in March).

5. The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from July 2009 – July 2014.

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

	Payment Months	Est. Ave. Monthly Beneficiaries	Est. Ave. Monthly Cost	Total Cost
FY 2014-15	12	1,307,490	$128,084,707	**$1,537,016,000**
FY 2015-16	12	1,361,246	$136,789,578	**$1,641,475,000**

Funding:

100% GF (4260-101-0001)

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

BASE POLICY CHANGE NUMBER:	170
IMPLEMENTATION DATE:	7/1990
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	23

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,359,930,000	$1,514,429,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,359,930,000	$1,514,429,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,359,930,000	$1,514,429,000

DESCRIPTION

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

Authority:
Interagency Agreement 01-15834

Interdependent Policy Changes:
Not Applicable

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

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

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

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

BASE POLICY CHANGE NUMBER: 170

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

(Dollars in Thousands)

	Total Funds	CDDS GF	DHCS FFP
FY 2014-15	$2,719,860	$1,359,930	**$1,359,930**
FY 2015-16	$3,028,858	$1,514,429	**$1,514,429**

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

DENTAL SERVICES

BASE POLICY CHANGE NUMBER:	171
IMPLEMENTATION DATE:	7/1988
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	135

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$795,450,000	$823,747,000
- STATE FUNDS	$377,632,250	$392,984,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$795,450,000	$823,747,000
STATE FUNDS	$377,632,250	$392,984,950
FEDERAL FUNDS	$417,817,750	$430,762,050

DESCRIPTION

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

Authority:
Social Security Act, Title XIX
AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:
Not Applicable

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

AB 82 restores partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services that can be offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including FQHCs and RHCs, will be limited to the adult optional benefits being restored May 1, 2014, in addition to the current scope of adult dental benefits which include services for pregnant women, emergency services, FRADs, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. The restoration of adult dental benefits is included in the capitation rates.

The Department will no longer apply the annual $1,800 beneficiary limit as a hard cap for dental services. If a beneficiary exceeds the $1,800 limit, the Department will authorize the dental fiscal intermediary to override the $1,800 limit so long as medical necessity is documented appropriately and/or a Treatment Authorization Request is submitted and approved in accordance with the dental Manual of Criteria. The capitation rates include the impact of implementing the change to $1,800 soft cap.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

Reason for Change from Prior Estimate:
Estimate is revised based on additional months of actual data from January 2014 through June 2014. Also, costs for Optional Targeted Low-Income Children's Program (OTLICP) eligibles have been added to this policy change. In FY 2013-14 their costs were included in the FFS amounts while in FY 2014-15 they were included in the capitated eligibles.

Methodology:

1. The proposed capitation rates for FY 2014-15 are $8.20 for regular eligibles and $5.94 for refugees. The same rates have been used for FY 2015-16.

2. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. Due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013, the next annual independent audit for the period of July 1, 2011 through June 31, 2013 was not completed until September 2014.

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

4. For FY 2014-15 and FY 2015-16 the impact of the Restoration of Adult Dental Benefits are included.

5. For FY 2014-15 and FY 2015-16 the impact of AB 97 is incorporated into the AB 97 policy change.

6. The capitation rates include the impact of implementing the change to $1,800 soft cap. For FY 2014-15 and FY 2015-16, the impact is $1,290,000 per fiscal year.

FY 2014-15	Rate	Average Eligible Months	Total Funds
Regular 7/14 – 6/15	$8.20	7,739,648	$ 761,581,000
Refugee 7/14 – 6/15	$5.94	2,531	$ 180,000
Other FFS	Non-Capitated		$ 58,551,000
		Subtotal	$ 820,312,000
Underwriting Gain			($24,862,000)
		FY 2014-15 Dental	**$ 795,450,000**
Restoration of Select Adult Dental Benefits (included in above dollars)			
Regular	$1.98	7,739,648	183,894,000
Refugee	$3.91	2,531	$ 119,000
			$ 184,013,000
$1,800 Soft Cap (included in above dollars)			$1,290,000

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

FY 2015-16	Rate	Average Eligible Months	Total Funds
Regular 7/15 – 6/16	$8.20	7,830,791	$ 770,550,000
Refugee 7/15 – 6/16	$5.94	2,549	$ 182,000
Other FFS	Non-Capitated		$ 53,015,000
		FY 2015-16 Dental	**$ 823,747,000**
Restoration of Select Adult Dental Benefits (included in above dollars)			
Regular	$1.98	7,830,791	$ 186,060,000
Refugee	$3.91	2,549	$ 120,000
			$ 186,180,000
$1,800 Soft Cap (included in above dollars)			$1,290,000

FY 2014-15	TF	GF	FF
Title XXI 65/35	$133,051,000	$46,568,000	$86,483,000
Enhanced Title XIX 65/35	$944,000	$330,000	$614,000
100% GF	$13,000	$13,000	$0
50/50 Title XIX	$661,442,000	$330,721,000	$330,721,000
Total	**$795,450,000**	**$377,632,000**	**$417,818,000**

FY 2015-16	TF	GF	FF
Title XXI 65/35	$125,023,000	$43,758,000	$81,265,000
Enhanced Title XIX 65/35	$944,000	$330,000	$614,000
100% GF	$13,000	$13,000	$0
50/50 Title XIX	$697,767,000	$348,883,000	$348,884,000
Total	**$823,747,000**	**$392,984,000**	**$430,763,000**

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

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER:	172
IMPLEMENTATION DATE:	7/1997
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	77

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$265,000,000	$265,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$265,000,000	$265,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$265,000,000	$265,000,000

DESCRIPTION

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

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

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

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

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

Methodology:
1. The following estimates have been provided by CDDS.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 172

CASH BASIS (In Thousands)	**Total Funds**	**CDDS GF**	**FFP Regular**	**Interagency Agreement**
FY 2014-15	$530,000	$265,000	**$265,000**	03-75282 03-75283
FY 2015-16	$530,000	$265,000	**$265,000**	03-75282 03-75283

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

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

BASE POLICY CHANGE NUMBER: 174
IMPLEMENTATION DATE: 7/1991
ANALYST: Jason Moody
FISCAL REFERENCE NUMBER: 26

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$191,787,000	$153,558,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$191,787,000	$153,558,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$191,787,000	$153,558,000

DESCRIPTION

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

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

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

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

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

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

BASE POLICY CHANGE NUMBER: 174

Methodology:

1. The following estimates have been provided by CDDS:

(In Thousands)

CASH BASIS	Total Funds	CDDS GF	DHCS FFP	IA #
FY 2014-15	$383,575	$191,788	**$191,787**	03-75284
FY 2015-16	$307,116	$153,558	**$153,558**	03-75284

Funding:

100% Title XIX (4260-101-0890)

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER:	177
IMPLEMENTATION DATE:	6/1995
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	27

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$41,394,000	$44,292,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$41,394,000	$44,292,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$41,394,000	$44,292,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

Background:
The TCM program provides funding to LGAs for assisting Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP). The TCM program, per the approved State Plan Amendment (SPA) #10-010, serves children under 21, medically fragile individuals 18 and over, individuals at risk of institutionalization, individuals at risk of negative health or psycho-social outcomes, and individuals with communicable diseases.

Reason for Change from Prior Estimate:
The change is due to lower participation rates.

Methodology:
1. SPA #10-010, approved on December 19, 2013, lifted the annual capitated amount effective July 1, 2014.

2. The projected payment amount for FY 2014-15 was based on average expenditures from FY 2011-12 through FY 2013-14 plus 2% for a rate increase and 10% for a SPA increase.

   $36,959,000 average expenditures x (1 + 2% rate increase + 10% SPA increase) = $41,394,000

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 177

3. The projected payment amount for FY 2015-16 was based on the FY 2014-15 estimated amount plus 2% for a rate increase and 5% for a SPA increase.

   $41,394,000 FY 2014-15 estimate x (1 + 2% rate increase + 5% SPA increase) = $44,292,000

(Dollars in Thousands)	TF	FF
FY 2014-15	**$41,394**	$41,394
FY 2015-16	**$44,292**	$44,292

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

EPSDT SCREENS

BASE POLICY CHANGE NUMBER:	178
IMPLEMENTATION DATE:	7/2001
ANALYST:	Peter Bjorkman
FISCAL REFERENCE NUMBER:	136

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$39,065,000	$39,065,000
- STATE FUNDS	$19,070,350	$19,070,350
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$39,065,000	$39,065,000
STATE FUNDS	$19,070,350	$19,070,350
FEDERAL FUNDS	$19,994,650	$19,994,650

DESCRIPTION

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

Authority:
Title 22, California Code of Regulations 51340(a)

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
The number of eligibles have increased starting January 2014, therefore the estimated number of screens have also increased.

Methodology:
Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2014-15 and FY 2015-16, based on a historical trend dating back to July 2009.

FY 2014-15
Screens 665,030 x $58.74 (weighted average) = **$39,065,000** (rounded)

FY 2015-16
Screens 665,030 x $58.74 (weighted average) = **$39,065,000** (rounded)

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 178

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

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	179
IMPLEMENTATION DATE:	4/2000
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	32

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$38,831,000	$40,858,000
- STATE FUNDS	$19,415,500	$20,429,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$38,831,000	$40,858,000
STATE FUNDS	$19,415,500	$20,429,000
FEDERAL FUNDS	$19,415,500	$20,429,000

DESCRIPTION

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

Authority:
AB 668 (Chapter 896, Statutes of 1998)
Interagency Agreement 03-75898

Interdependent Policy Changes:
PC 40 California Community Transitions Costs

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

Reason for Change from Prior Estimate:
Costs have increased slightly based on updated actual utilization data.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 179

Methodology:

1. Assume the number of current NF A/B Level of Care (LOC) Waiver beneficiaries using Waiver PCS is estimated to increase by an average of ten per month in FY 2014-15 and FY 2015-16.

2. Assume the number of current NF Subacute (SA) LOC beneficiaries using Waiver PCS is estimated to increase by one per month in FY 2014-15 and FY 2015-16.

3. The Department's CCT Demonstration Project expects to transition 500 beneficiaries out of inpatient extended health care facilities during FY 2014-15, and 551 beneficiaries during FY 2015-16. Based on actual data, 5% of the beneficiaries are expected to use Waiver PCS.

4. The average cost/hour is $10.36 for FY 2014-15 and FY 2015-16.

Funding:

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

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER:	183
IMPLEMENTATION DATE:	7/1989
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	93

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$7,921,000	$1,865,000
- STATE FUNDS	$3,959,500	$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,921,000	$1,865,000
STATE FUNDS	$3,959,500	$932,500
FEDERAL FUNDS	$3,961,500	$932,500

DESCRIPTION

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

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
An additional lawsuit settlement has been added (Maternal and Child Health Access).

Methodology:

1. Provider Settlements of $75,000 or Less Payments

1. Catholic Healthcare West	$9,879
2. Daughters of Charity Health System	$18,717
3. AHMC San Gabriel Valley Medical Center	$4,439
4. East Los Angeles Doctors Inc.	$5,996
5. Good Samaritan Hospital	$3,744
6. Pioneers Memorial Healthcare District	$511
7. Prime Healthcare Services	$44,975
8. AHMC Greater El Monte Community Hospital	$11,562
9. Daughters of Charity Health System	$4,875
10. CFHS Holdings, Inc.	$649

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 183

11. Alta Hospitals System	$1,662
12. CFHS Holdings, Inc	$2,528
13. Long Beach Memorial Medical Center	$750
14. CFHS Holdings, Inc	$1,356
Total	**$111,643**

2. Other Attorney Fees Payments

1. Maternal and Child Health Access	$60,538
2. Nossaman, LLB (Santa Clara County)	$496,968
3. Mark Woodsmall, Esq	$8,550
Total	**$566,056**

3. Other Provider Settlements / Judgments Payments

1. Santa Clara County Health Authority	$5,500,000
Total	**$5,500,000**

	Committed 2014-15	Balance 2014-15	Budgeted 2014-15		Budgeted 2015-16	
Attorney Fees <$5,000	$0	$41,450	$41,450	*	$50,000	*
Provider Settlements <$75,000	$111,643	$1,488,357	$1,600,000	*	$1,600,000	*
Beneficiary Settlements <$2,000	$0	$15,000	$15,000	*	$15,000	*
Small Claims Court	$0	$200,000	$200,000	*	$200,000	*
Other Attorney Fees	$566,056	N/A	$566,056	*	$0	
Other Provider Settlements	$5,500,000	N/A	$5,500,000	*	$0	
Other Beneficiary Settlements	($2,000)	N/A	($2,000)		$0	
	$6,175,699	$1,744,807	**$7,921,000**		**$1,865,000**	

* Represents potential totals.

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

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	185
IMPLEMENTATION DATE:	1/1993
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	91

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$2,243,000	$2,356,000
- STATE FUNDS	$1,121,500	$1,178,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,243,000	$2,356,000
STATE FUNDS	$1,121,500	$1,178,000
FEDERAL FUNDS	$1,121,500	$1,178,000

DESCRIPTION

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

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

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
As a result of the Department's migration from fee-for-service to managed care, FY 2014-15 costs are lower than previously projected due to decreases in enrollment. In addition, based on updated HIPP expenditure and enrollment data, the average monthly premium costs were lower than previously estimated.

Methodology:
1. In FY 2015-16, it is anticipated that there will be no growth in enrollment and the insurance premiums will increase by 5%.

2. The average monthly premium cost is estimated to be $665.29 in FY 2014-15 and $698.56 in FY 2015-16.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

3. The average monthly HIPP enrollment is estimated to be 281 in FY 2014-15 and FY 2015-16.

4. Costs for FY 2014-15 and FY 2015-16 are estimated to be:

   FY 2014-15: $665.29 x 281 x 12 Months = **$2,243,000 TF ($1,121,500 GF)**

   FY 2015-16: $698.56 x 281 x 12 Months = **$2,356,000 TF ($1,178,000 GF)**

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

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER:	187
IMPLEMENTATION DATE:	7/1997
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1083

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,799,000	$1,285,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,799,000	$1,285,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,799,000	$1,285,000

DESCRIPTION

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

Authority:
Interagency Agreement (IA) #07-65689

Interdependent Policy Changes:
Not Applicable

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

Reason for Change from Prior Estimate:
The changes are due to:
- Contract approval delay
- Local jurisdictions invoicing delays to CDPH

Methodology:
1. Annual expenditures on the accrual basis are $2,056,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

2. The estimates are provided by CDPH on a cash basis.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 187

(In Thousands) **FY 2014-15**	**DHCS FFP**	**CDPH CLPP Fee Funds**
Benefits Costs	**$1,799**	$1,799

FY 2015-16	**DHCS FFP**	**CDPH CLPP Fee Funds**
Benefits Costs	**$1,285**	$1,285

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

BASE RECOVERIES

BASE POLICY CHANGE NUMBER:	195
IMPLEMENTATION DATE:	7/1987
ANALYST:	Toni Richardson
FISCAL REFERENCE NUMBER:	127

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$268,768,000	-$265,697,000
- STATE FUNDS	-$135,282,000	-$133,736,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$268,768,000	-$265,697,000
STATE FUNDS	-$135,282,000	-$133,736,000
FEDERAL FUNDS	-$133,486,000	-$131,961,000

DESCRIPTION

Purpose:
This policy change estimates estates, personal injury, provider/beneficiary overpayment, and other insurance collections used to offset the cost of Medi-Cal services.

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

Interdependent Policy Changes:
Not Applicable

Background:
Recoveries credited to the Health Care Deposit Fund finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, personal injury, provider/beneficiary overpayments, and other insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

Reason for Change from Prior Estimate:
Increased recoveries for FY 2014-15 are due to additional health insurance contract collections.

Methodology:
1. The recoveries estimate uses the trend in the monthly recoveries for July 2011 – July 2014.

2. The General Fund ratio for collections is estimated to be 50.33% in FY 2014-15 and FY 2015-16.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 195

(Dollars in Thousands)

Estimated Base Recoveries	FY 2014-15	FY 2015-16
Personal Injury Collections	($51,616)	($51,786)
Workers' Comp. Contract	($3,380)	($3,380)
H.I. Contingency Contract	($64,599)	($60,000)
General Collections	($149,173)	($150,531)
TOTAL	**($268,768)**	**($265,697)**

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

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

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2	BREAST AND CERVICAL CANCER TREATMENT
3	MEDI-CAL ACCESS PROGRAM MOTHERS 200-300% FPL
4	MEDI-CAL ADULT INMATE PROGRAMS
5	MEDI-CAL ACCESS PROGRAM INFANTS 250-300% FPL
6	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES
7	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
9	REFUGEES
10	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE
11	NEW QUALIFIED IMMIGRANTS
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	SCHIP FUNDING FOR PRENATAL CARE
14	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
15	INCARCERATION VERIFICATION PROGRAM
16	PARIS-VETERANS
17	TLICP PREMIUMS
	AFFORDABLE CARE ACT
18	ACA OPTIONAL EXPANSION
19	ACA MANDATORY EXPANSION
20	ACA EXPRESS LANE ENROLLMENT
21	PAYMENTS TO PRIMARY CARE PHYSICIANS
22	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY
23	COMMUNITY FIRST CHOICE OPTION
24	ACA DELAY OF REDETERMINATIONS
25	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS
26	HEALTH INSURER FEE
27	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS
28	USPSTF GRADE A AND B RECOMMENDATIONS
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES
30	STATE-ONLY FORMER FOSTER CARE PROGRAM
31	ACA MAGI SAVINGS
32	RECOVERY AUDIT CONTRACTOR SAVINGS MANAGED
34	CARE DRUG REBATES

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35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
36	BEHAVIORAL HEALTH TREATMENT
37	LOCAL EDUCATION AGENCY (LEA) PROVIDERS
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA
39	CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS
41	DENTAL CHILDREN'S OUTREACH AGES 0-3
42	VOLUNTARY INPATIENT DETOXIFICATION
43	YOUTH REGIONAL TREATMENT CENTERS
44	CCT FUND TRANSFER TO CDSS AND CDDS
45	PEDIATRIC PALLIATIVE CARE WAIVER
46	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER
47	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS
48	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT
49	CHDP PROGRAM DENTAL REFERRAL
50	WOMEN'S HEALTH SERVICES
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS
201	ALLIED DENTAL PROFESSIONALS ENROLLMENT
202	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS
	PHARMACY
52	RESTORATION OF ENTERAL NUTRITION BENEFIT
53	PEDIATRIC MOBILE VISION PROJECT
54	NON FFP DRUGS
55	BCCTP DRUG REBATES
56	MEDICAL SUPPLY REBATES
57	LITIGATION SETTLEMENTS
58	FAMILY PACT DRUG REBATES
59	STATE SUPPLEMENTAL DRUG REBATES
60	AGED AND DISPUTED DRUG REBATES
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MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

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67	ANNUAL RATE ADJUSTMENT
	MENTAL HEALTH
71	ELIMINATION OF STATE MAXIMUM RATES
72	TRANSITION OF HFP - SMH SERVICES
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74	INTERIM AND FINAL COST SETTLEMENTS - SMHS
75	INVESTMENT IN MENTAL HEALTH WELLNESS
76	HEALTHY FAMILIES - SED
77	OVER ONE-YEAR CLAIMS
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79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
80	IMD ANCILLARY SERVICES
81	CHART REVIEW
	WAIVER--MH/UCD & BTR
82	MH/UCD & BTR—DSH PAYMENT
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
85	BTR - LIHP - MCE
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
87	BTR—SAFETY NET CARE POOL
88	MH/UCD & BTR—CCS AND GHPP
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—DPH INTERIM & FINAL RECONS
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
93	BTR—DESIGNATED STATE HEALTH PROGRAMS
94	MH/UCD & BTR—DPH INTERIM RATE GROWTH
95	MH/UCD—SAFETY NET CARE POOL
96	BTR—INCREASE SAFETY NET CARE POOL
97	MH/UCD—STABILIZATION FUNDING
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
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101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
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103	MH/UCD & BTR—BCCTP
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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.

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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

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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.

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(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)

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE SUMMARY
FISCAL YEAR 2014-15

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES PROCEDURAL	ONE-TIME CHANGES CASELOAD	ON-GOING CHANGES PROCEDURAL	ON-GOING CHANGES CASELOAD	TOTAL POLICY CHANGE	TOTAL STATE FUNDS
	OTHER						
1	COUNTY ADMINISTRATION BASE	$0	$0	$1,302,683,000	$0	$1,302,683,000	$651,341,500
2	IMPLEMENTATION OF ACA	$0	$390,000,000	$0	$0	$390,000,000	$195,000,000
3	SAWS	$188,330,000	$0	$0	$0	$188,330,000	$8,734,500
4	PRIOR YEAR PAYMENT	$124,000,000	$0	$0	$0	$124,000,000	$62,000,000
5	CalWORKS APPLICATIONS	$0	$0	$70,634,000	$0	$70,634,000	$35,317,000
6	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$40,198,000	$40,198,000	$14,069,300
7	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$26,843,000	$26,843,000	$2,075,000
8	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	-$371,022,000
9	SAVE	$0	$0	$0	$0	$0	-$3,500,000
10	PRIOR YEAR RECONCILIATIONS	-$2,309,000	$0	$0	$0	-$2,309,000	-$1,154,500
	OTHER SUBTOTAL	**$310,021,000**	**$390,000,000**	**$1,373,317,000**	**$67,041,000**	**$2,140,379,000**	**$592,860,800**
	GRAND TOTAL	**$310,021,000**	**$390,000,000**	**$1,373,317,000**	**$67,041,000**	**$2,140,379,000**	**$592,860,800**

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE SUMMARY
FISCAL YEAR 2015-16

NO.	POLICY CHANGE TITLE	ONE-TIME CHANGES PROCEDURAL	ONE-TIME CHANGES CASELOAD	ON-GOING CHANGES PROCEDURAL	ON-GOING CHANGES CASELOAD	TOTAL POLICY CHANGE	TOTAL STATE FUNDS
	OTHER						
1	COUNTY ADMINISTRATION BASE	$0	$0	$1,302,683,000	$0	$1,302,683,000	$651,341,500
2	IMPLEMENTATION OF ACA	$0	$240,000,000	$0	$0	$240,000,000	$120,000,000
3	SAWS	$157,234,000	$0	$0	$0	$157,234,000	$9,487,500
5	CalWORKS APPLICATIONS	$0	$0	$71,549,000	$0	$71,549,000	$35,774,500
6	CASE MANAGEMENT FOR OTLICP	$0	$0	$0	$40,198,000	$40,198,000	$14,069,300
7	LOS ANGELES COUNTY HOSPITAL INTAKES	$0	$0	$0	$18,470,000	$18,470,000	$3,561,000
8	ENHANCED FEDERAL FUNDING	$0	$0	$0	$0	$0	-$271,693,000
9	SAVE	$0	$0	$0	$0	$0	-$3,500,000
10	PRIOR YEAR RECONCILIATIONS	-$2,309,000	$0	$0	$0	-$2,309,000	-$1,154,500
	OTHER SUBTOTAL	**$154,925,000**	**$240,000,000**	**$1,374,232,000**	**$58,668,000**	**$1,827,825,000**	**$557,886,300**
	GRAND TOTAL	**$154,925,000**	**$240,000,000**	**$1,374,232,000**	**$58,668,000**	**$1,827,825,000**	**$557,886,300**

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
NOVEMBER 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2014-15

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		DIFFERENCE	
			TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
		OTHER						
1	1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$0	$0
2	3	SAWS	$148,953,000	$0	$188,330,000	$8,734,500	$39,377,000	$8,734,500
3	2	IMPLEMENTATION OF ACA	$240,000,000	$120,000,000	$390,000,000	$195,000,000	$150,000,000	$75,000,000
4	5	CalWORKS APPLICATIONS	$69,684,000	$34,842,000	$70,634,000	$35,317,000	$950,000	$475,000
5	6	CASE MANAGEMENT FOR OTLICP	$40,198,000	$14,069,300	$40,198,000	$14,069,300	$0	$0
7	7	LOS ANGELES COUNTY HOSPITAL INTAKES	$15,313,000	$3,561,500	$26,843,000	$2,075,000	$11,530,000	-$1,486,500
11	9	SAVE	$0	-$3,500,000	$0	-$3,500,000	$0	$0
13	10	PRIOR YEAR RECONCILIATIONS	-$1,297,000	-$648,500	-$2,309,000	-$1,154,500	-$1,012,000	-$506,000
14	8	ENHANCED FEDERAL FUNDING	$0	-$248,402,000	$0	-$371,022,000	$0	-$122,620,000
--	4	PRIOR YEAR PAYMENT	$0	$0	$124,000,000	$62,000,000	$124,000,000	$62,000,000
		OTHER SUBTOTAL	**$1,815,534,000**	**$571,263,800**	**$2,140,379,000**	**$592,860,800**	**$324,845,000**	**$21,597,000**
		COUNTY ADMINISTRATION GRAND TOTAL	**$1,815,534,000**	**$571,263,800**	**$2,140,379,000**	**$592,860,800**	**$324,845,000**	**$21,597,000**

Costs shown do not include percent reflected in base calculation.

COMPARISON OF FISCAL IMPACTS OF COUNTY ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

NOV. PC#	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	NOV. 2014 EST. FOR 2015-16 TOTAL FUNDS	NOV. 2014 EST. FOR 2015-16 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
	OTHER						
1	COUNTY ADMINISTRATION BASE	$1,302,683,000	$651,341,500	$1,302,683,000	$651,341,500	$0	$0
2	IMPLEMENTATION OF ACA	$390,000,000	$195,000,000	$240,000,000	$120,000,000	-$150,000,000	-$75,000,000
3	SAWS	$188,330,000	$8,734,500	$157,234,000	$9,487,500	-$31,096,000	$753,000
4	PRIOR YEAR PAYMENT	$124,000,000	$62,000,000	$0	$0	-$124,000,000	-$62,000,000
5	CalWORKS APPLICATIONS	$70,634,000	$35,317,000	$71,549,000	$35,774,500	$915,000	$457,500
6	CASE MANAGEMENT FOR OTLICP	$40,198,000	$14,069,300	$40,198,000	$14,069,300	$0	$0
7	LOS ANGELES COUNTY HOSPITAL INTAKES	$26,843,000	$2,075,000	$18,470,000	$3,561,000	-$8,373,000	$1,486,000
8	ENHANCED FEDERAL FUNDING	$0	-$371,022,000	$0	-$271,693,000	$0	$99,329,000
9	SAVE	$0	-$3,500,000	$0	-$3,500,000	$0	$0
10	PRIOR YEAR RECONCILIATIONS	-$2,309,000	-$1,154,500	-$2,309,000	-$1,154,500	$0	$0
	OTHER SUBTOTAL	**$2,140,379,000**	**$592,860,800**	**$1,827,825,000**	**$557,886,300**	**-$312,554,000**	**-$34,974,500**
	COUNTY ADMINISTRATION GRAND TOTAL	**$2,140,379,000**	**$592,860,800**	**$1,827,825,000**	**$557,886,300**	**-$312,554,000**	**-$34,974,500**

Costs shown do not include percent reflected in base calculation.

MEDI-CAL COUNTY ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
1	COUNTY ADMINISTRATION BASE
2	IMPLEMENTATION OF ACA
3	SAWS
4	PRIOR YEAR PAYMENT
5	CalWORKS APPLICATIONS
6	CASE MANAGEMENT FOR OTLICP
7	LOS ANGELES COUNTY HOSPITAL INTAKES
8	ENHANCED FEDERAL FUNDING
9	SAVE
10	PRIOR YEAR RECONCILIATIONS

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1704

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$1,302,683,000	$0	$1,302,683,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$1,302,683,000	$0	$1,302,683,000
STATE FUNDS	$0	$651,341,500	$0	$651,341,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$1,302,683,000	$0	$1,302,683,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$1,302,683,000	$0	$1,302,683,000
STATE FUNDS	$0	$651,341,500	$0	$651,341,500

DESCRIPTION

This policy change reflects the base allocation funded to counties for costs associated with Medi-Cal eligibility determination activities.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Department is responsible for determining the appropriate allocation for funding county welfare department costs associated with Medi-Cal eligibility determinations. The Department establishes and maintains a cost control plan. The plan provides for the administrative costs that the counties incur for Medi-Cal eligibility determination activities. The base estimate reflects the allocation to the counties utilizing recent workload data, county expenditure data, and other county-submitted information.

The base estimate consists of the costs identified for three sub-categories: (1) staff costs (2) staff development, and (3) support costs.

1. Staff Costs
   This amount includes the estimated costs for staff in three staff categories: eligibility workers and supervisors, clerical support staff, and administrative staff. The staff costs for each of the three categories will be allocated to individual counties to fund all Medi-Cal eligibility determination activities.

COUNTY ADMINISTRATION BASE

COUNTY ADMIN. POLICY CHANGE NUMBER: 1

2. Support Costs
   Support costs are a combination of two types of expenditures: operating support costs and electronic data processing costs. These two types of expenditures are further divided into allocated costs and direct costs.
   a. Allocated costs are those that are shared across all programs and distributed to individual programs based on a ratio developed from the total expenditures for each program.
   b. Direct costs are specific to the Medi-Cal program only.

3. Staff Development
   Staff development costs are the costs of training Medi-Cal eligibility workers. The amount in this item includes:
   a. Trainers' salaries and benefits.
   b. Operating costs related to training.
   c. Trainees' salaries and benefits.
   d. Travel, per diem, supplies and tuition.
   e. Purchase of contracted training services.

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

Methodology:

(Dollars in Thousands)

Base Allocation	TF	GF	FF
FY 2014-15	**$1,302,683**	**$651,341**	**$651,342**
FY 2015-16	**$1,302,683**	**$651,341**	**$651,342**

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

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1796

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$390,000,000	$0	$240,000,000	$0
TOTAL FUNDS	$390,000,000	$0	$240,000,000	$0
STATE FUNDS	$195,000,000	$0	$120,000,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$390,000,000	$0	$240,000,000	$0
TOTAL FUNDS	$390,000,000	$0	$240,000,000	$0
STATE FUNDS	$195,000,000	$0	$120,000,000	$0

DESCRIPTION

This policy change estimates the county administrative costs for implementing required provisions of the Affordable Care Act (ACA).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, the ACA expands Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The 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 ACA mandatory expansions.

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. The ACA also requires states to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs.

IMPLEMENTATION OF ACA

COUNTY ADMIN. POLICY CHANGE NUMBER: 2

Covered California offers applicants the option to file online, in person, by mail, by telephone with the exchange, or with the county welfare departments (CWD). To meet this requirement, the Department and Covered California formed a partnership to develop the CalHEERS system. CalHEERS allows for the one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.

Reason for Change from Prior Estimate:
The Department added $150 million of ACA implementation funding in FY 2014-15 and $240 million in FY 2015-16.

Methodology:

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

2. Since January 2014, the Department has experienced significant growth in Medi-Cal enrollment as result of both the ACA optional and ACA mandatory expansions.

3. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) was developed to automate the eligibility work for a large portion of new and existing Medi-Cal beneficiaries. However, currently the system isn't completely functional. This requires counties to manually process some eligibility determinations and renewals. These manual workarounds performed by the counties require additional resources.

4. Total county administrative costs for implementing required provisions of the ACA are:

(Dollars in Thousands)

FY 2014-15		FY 2015-16	
TF	**GF**	**TF**	**GF**
$390,000	**$195,000**	**$240,000**	**$120,000**

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

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	7/1987
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	214

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$188,330,000	$0	$157,234,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$188,330,000	$0	$157,234,000	$0
STATE FUNDS	$8,734,500	$0	$9,487,500	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$188,330,000	$0	$157,234,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$188,330,000	$0	$157,234,000	$0
STATE FUNDS	$8,734,500	$0	$9,487,500	$0

DESCRIPTION

Purpose:
This policy change estimates and reimburses the California Department of Social Services (CDSS) 100% Federal Financial Participation (FFP) for automated Eligibility Determination and Automated Benefit Computation. This policy change also estimates the funds for the Los Angeles Eligibility Automated Determination Evaluation and Reposting System (LEADER) that is paid by the Department.

Authority:
Welfare & Institutions Code 14154
Interagency Agreement #04-35639
Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
The Statewide Automated Welfare Systems (SAWS) consists of three county consortium systems: LEADER, the Consortium-IV (C-IV), and the CalWORKs Information Network (CalWIN).

The SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

LEADER is the automated system for Los Angeles County and is currently in the maintenance and operation phase. The County began the process to replace the LEADER system and has entered the

SAWS

COUNTY ADMIN. POLICY CHANGE NUMBER: 3

development phase of the process with the contractor Accenture. The Center for Medicaid and Medicare Services (CMS), OSI and the County board of supervisors have reviewed and approved the LEADER Replacement System (LRS) development contract. While the replacement system is being developed, the County received state and federal approval to extend the existing LEADER maintenance and operations contract for an additional two years, through April 2015. To accommodate the current LRS development and implementation schedule, the County and OSI are preparing a request to extend this contract for up to two more years, through April 2017.

The CalWIN consortium is fully implemented in all 18 counties and is currently in the maintenance and operation phase.

The C-IV system is fully implemented in 39 counties and is currently in the maintenance and operation phase.

The State Strategy for Eligibility Systems and ABX1 16 (Chapter 13, Statutes of 2011) dictate the migration of the 39 C-IV counties into a system jointly designed by the C-IV counties and Los Angeles County under the LRS contract. The timeline for the C-IV Migration has not been set and is dependent upon the successful implementation of LRS in Los Angeles County. The C-IV Migration will result in a new consortium to replace the LEADER and C-IV consortia.

Counties in all three of the SAWS have upgraded and expanded the current county call center infrastructure to interface with Covered California's service center. This expansion is required to meet the increase in call volume and the increase in services provided to beneficiaries.

Reason for Change from Prior estimate:
Updated CDSS FY 2014-15 expenditures.

Methodology:

1. The cash basis estimate was provided by CDSS.

(Dollars In Thousands)	FY 2014-15	FY 2015-16
LA County LEADER M&O*	$17,469	$18,975
LEADER Replacement	$81,309	$64,856
SAWS Customer Service Center	$4,654	$0
SPM	$1,667	$1,992
WCDS-CalWIN	$30,552	$37,228
Consortia IV	$28,351	$34,114
State Client Index	$69	$69
CalHEERS Development	$21,240	$0
CAlHEERS Interface M&O	$2,915	$0
Consortium-IV Migration	$104	$0
Total	**$188,330**	**$157,234**

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

PRIOR YEAR PAYMENT

COUNTY ADMIN. POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/2014
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1869

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$124,000,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$124,000,000	$0	$0	$0
STATE FUNDS	$62,000,000	$0	$0	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$124,000,000	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$124,000,000	$0	$0	$0
STATE FUNDS	$62,000,000	$0	$0	$0

DESCRIPTION

Purpose:
This policy change addresses the balance of the FY 2013-14 fourth quarter county administration payment due to the counties.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Department experienced a funding deficit in June 2014. This deficit was the result of a cash flow issue which created a shortage in the county administration funds available in the fourth quarter of FY 2013-14. The counties received a partial payment in FY 2013-14 with the balance to be paid to each county in July 2014.

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

Methodology:
1. The amount of the FY 2013-14 payment delay until July 2014 is:

PRIOR YEAR PAYMENT

COUNTY ADMIN. POLICY CHANGE NUMBER: 4

(Dollars in Thousands)

FY 2014-15	TF	GF	FF
Total FY 2014-15	**$124,000**	**$62,000**	$62,000

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

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	7/1998
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	217

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$70,634,000	$0	$71,549,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$70,634,000	$0	$71,549,000
STATE FUNDS	$0	$35,317,000	$0	$35,774,500
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$70,634,000	$0	$71,549,000
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$70,634,000	$0	$71,549,000
STATE FUNDS	$0	$35,317,000	$0	$35,774,500

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal portion of the shared costs for processing applications which are submitted through CalWORKS and/or CalFresh programs. These costs include staff and support costs.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Since 1998, the Department shares in the costs for CalWORKS applications with the California Department of Social Services (CDSS). CDSS amended the claim forms and time study documents, completed by the counties to allow CalWORKS application costs that are also necessary for Medi-Cal and CalFresh eligibility, to be shared between the three programs.

Reason for Change from Prior Estimate:
CDSS updated estimated FY 2014-15 and FY 2015-16 expenditures.

CalWORKS APPLICATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 5

Methodology:

1) The estimated costs for FY 2014-15 and FY 2015-16 were provided on a cash basis from CDSS.

	TF	GF	FF
FY 2014-15	**$70,634,000**	**$35,317,000**	**$35,317,000**
FY 2015-16	**$71,549,000**	**$35,774,500**	**$35,774,500**

Funding:

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

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	12/2012
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1598

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$40,198,000	$0	$40,198,000
TOTAL FUNDS	$0	$40,198,000	$0	$40,198,000
STATE FUNDS	$0	$14,069,300	$0	$14,069,300
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$40,198,000	$0	$40,198,000
TOTAL FUNDS	$0	$40,198,000	$0	$40,198,000
STATE FUNDS	$0	$14,069,300	$0	$14,069,300

DESCRIPTION

Purpose:
This policy change budgets the county administration costs associated with the ongoing costs for case management and redetermination of Optional Targeted Low Income Children's Program (OTLICP) beneficiaries.

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP sent to the counties the current subscribers' applications and information. The final group transitioned November 1, 2013. The program has since been renamed as the OTLICP.

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

CASE MANAGEMENT FOR OTLICP

COUNTY ADMIN. POLICY CHANGE NUMBER: 6

Methodology:

1. The Department currently estimates the case management and redetermination for the former OTLICP beneficiaries at $4.00 PMPM.

2. Estimated costs:

(In Thousands)

	TF	GF
FY 2014-15	**$40,198**	**$14,069**
FY 2015-16	**$40,198**	**$14,069**

Funding:

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

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/1994
ANALYST: Joanne Peschko
FISCAL REFERENCE NUMBER: 213

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$26,843,000	$0	$18,470,000
TOTAL FUNDS	$0	$26,843,000	$0	$18,470,000
STATE FUNDS	$0	$2,075,000	$0	$3,561,000
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$26,843,000	$0	$18,470,000
TOTAL FUNDS	$0	$26,843,000	$0	$18,470,000
STATE FUNDS	$0	$2,075,000	$0	$3,561,000

DESCRIPTION

Purpose:
The policy change estimates the costs for Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Los Angeles County uses PFSWs to collect and process Medi-Cal applications taken in Los Angeles County hospitals. The applications processed by the PFSWs are sent to the Los Angeles County Human Services Agency for final eligibility determination. Welfare & Institutions Code Section 14154 limits the reimbursement amount for PFSW intakes to the amount paid to Los Angeles County Department of Social Services (DPSS) eligibility workers for regular Medi-Cal intakes. The federal share for any costs not covered by the DPSS rate is passed through to the county.

Reason for Change from Prior Estimate:
Expenditures include updated data from the Los Angeles Hospital System.

Methodology:
1. The Department is anticipating an increase in the number of intakes due to the Affordable Care Act; therefore, the Department plans to freeze the funding for FY 2014-15 at FY 2012-13 levels. These

LOS ANGELES COUNTY HOSPITAL INTAKES

COUNTY ADMIN. POLICY CHANGE NUMBER: 7

intakes are reported separately to the Department and are not included in the base estimate. The average reimbursement rate is $268 for both current year and budget year. Assume in FY 2014-2015 and FY 2015-2016, PFSWs will continue processing at 2,215 per month.

FY 2014-15: 2,215 x $268 x 12 = $7,123,000 ($3,561,500 GF)
FY 2015-16: 2,215 x $268 x 12 = $7,123,000 ($3,561,500 GF)

2. In FY 2014-15, the Department completed the FY 2012-2013 Los Angeles County Hospital Intakes reconciliation. The reconciliation resulted in a refund to Los Angeles of approximately $8,176,000, which includes a federal pass-through of $9,761,000 due to the county. The net result is lower due to $1,585,410 owed to the Department for processing a lower number of intakes. Assume the same amount of federal fund pass-through is needed in FY 2015-16 for the reconciliation of FY 2013-14.

(Dollars in Thousands)

	FY 2014-15			FY 2015-16		
	TF	**GF**	**FF**	**TF**	**GF**	**FF**
PFSW Base	$7,123	$3,561	$3,562	$7,123	$3,561	$3,562
FY 2010-11 Recon.	$197	$99	$98	$0	$0	$0
FY 2012-13 Recon.	$8,176	($1,585)	$9,761	$0	$0	$0
FY 2012-13 Pass.	$11,347	$0	$11,347	$11,347	$0	$11,347
Total	**$26,843**	**$2,075**	**$24,768**	**$18,470**	**$3,561**	**$14,909**

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

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	1/2015
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1835

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$371,022,000	$0	-$271,693,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$371,022,000	$0	-$271,693,000	$0

DESCRIPTION

Purpose:
This policy change estimates the savings from enhanced federal funding for certain eligibility determination functions.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Generally, payments to counties for making Medi-Cal eligibility determinations are budgeted at 50% federal funding. However, the Centers for Medicare and Medicaid Services (CMS) published guidance that allows for federal funding at 75% for some of these activities. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.

In order to secure the enhanced funding, there are various conditions required of a MMIS. Also, there are minimum critical success factors for accepting the new applications, making modified adjusted gross income (MAGI) determinations and coordination with Covered California. The Department must submit an advanced planning document (APD) and secure CMS approval.

ENHANCED FEDERAL FUNDING

COUNTY ADMIN. POLICY CHANGE NUMBER: 8

Reason for Change from Prior Estimate:
There was a change in the effective date for approval of the Department's APD from January 1, 2014 to April1, 2014. CMS approved the APD on September 29, 2014. Also, FY 2014-15, Quarter 2-Quarter 4 includes funding from the implementation of the Affordable Care Act (ACA).

Methodology:

1. The effective date for the approval for the Department's ADP is September 29, 2014, with retroactivity for April-September 2014. In addition, FY 2014-15 contains funding for the implementation of the ACA.

2. Assume that 70% of county administration forecasted expenditure costs are eligible for the enhanced funding because they are application, on-going case maintenance, and redetermination costs.

3. The savings are estimated to be:

FY 2014-15	**TF**	**GF**	**FF**
FY 2013-14 Q4 retro at 50% FFP	$282,005,000	$141,002,500	$141,002,500
FY 2013-14 Q4 retro at 75% FFP	$282,005,000	$211,503,750	$70,501,250
Total	$0	($70,501,250)	$70,501,250
FY 2014-15 Q1 retro at 50% FFP	$282,005,000	$141,002,500	$141,002,500
FY 2014-15 Q1 retro at 75% FFP	$282,005,000	$211,503,750	$70,501,250
Total	$0	($70,501,250)	$70,501,250
FY 2014-15 Q2-Q4 at 50% FFP	$815,077,000	$407,538,500	$407,538,500
FY 2014-15 Q2-Q4 at 50% FFP (ACA)	$105,000,000	$52,500,000	$52,500,000
FY 2014-15 Q2-Q4 at 75% FFP	$815,077,000	$203,769,250	$611,307,750
FY 2014-15 Q2-Q4 at 75% FFP (ACA)	$105,000,000	$26,250,000	$78,750,000
Total	$0	($230,019,250)	$230,019,250
Total Difference	**$0**	**($371,021,750)**	**$371,021,750**
FY 2015-16			
FY 2015-16 at 50% FFP	$1,086,770,000	$543,385,000	$543,385,000
FY 2015-16 at 75% FFP	$1,086,770,000	$271,692,000	$815,078,000
Total Difference	**$0**	**($271,693,000)**	**$271,693,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	10/1988
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	215

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$3,500,000	$0	-$3,500,000	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	$0	$0	$0	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	$0	$0	$0	$0
STATE FUNDS	-$3,500,000	$0	-$3,500,000	$0

DESCRIPTION

Purpose:
The policy change estimates the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for the Systematic Alien Verification for Entitlements (SAVE) system.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
The Immigration Reform and Control Act (IRCA) of 1986 required states to use the SAVE system to verify alien status for Medi-Cal applicants beginning in October 1988. The counties complete time studies for eligibility workers and supervisors based on time spent for SAVE verifications.

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

Methodology:
1. The Medi-Cal accrual costs for SAVE reported over the last five years by the counties were:

FY 2010-11*	$6,431,214
FY 2011-12*	$6,418,702
FY 2012-13**	$6,417,908

SAVE

COUNTY ADMIN. POLICY CHANGE NUMBER: 9

FY 2013-14**	$7,000,000
FY 2014-15**	$7,000,000
FY 2015-16**	$7,000,000

2. Based on claims through June 2012, federal funds will be:

	Total Fund	FF Shift
FY 2014-15	$7,000,000	**$3,500,000**
FY 2015-16	$7,000,000	**$3,500,000**

* Actual
** Preliminary

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

PRIOR YEAR RECONCILIATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	12/2011
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1191

	FY 2014-15		FY 2015-16	
	ONE-TIME	ON-GOING	ONE-TIME	ON-GOING
PROCEDURAL - TOT.	-$2,309,000	$0	-$2,309,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	-$2,309,000	$0	-$2,309,000	$0
STATE FUNDS	-$1,154,500	$0	-$1,154,500	$0
% IN BASE				
PROCEDURAL	0.00 %	0.00 %	0.00 %	0.00 %
CASELOAD	0.00 %	0.00 %	0.00 %	0.00 %
APPLIED TO BASE				
PROCEDURAL - TOT.	-$2,309,000	$0	-$2,309,000	$0
CASELOAD - TOT.	$0	$0	$0	$0
TOTAL FUNDS	-$2,309,000	$0	-$2,309,000	$0
STATE FUNDS	-$1,154,500	$0	-$1,154,500	$0

DESCRIPTION

Purpose:
This policy change estimates the reconciliation of county administration expenditures to the county administration allocation.

Authority:
Welfare & Institutions Code 14154

Interdependent Policy Changes:
Not Applicable

Background:
Two years following the end of a fiscal year, county administration expenditures are reconciled to the county administration allocation for the applicable fiscal year. Counties have one year from the end of a quarter to amend their quarterly administrative claim which is used by the Department for the county administration reconciliation process.

Reason for Change from Prior Estimate:
The Department adjusted the FY 2012-13 interim and final reconciliation amount based upon actual collections and historical, respectively.

Methodology:
1) In FY 2014-15, the Department completed the interim reconciliation for FY 2012-13 and final reconciliation for FY 2012-13. The final reconciliation of FY 2012-13 includes all final amendments and adjustments to the quarterly administrative claim.

PRIOR YEAR RECONCILIATIONS

COUNTY ADMIN. POLICY CHANGE NUMBER: 10

2) In FY 2015-16, the Department will complete the final reconciliation for FY 2013-14.

(Dollars in Thousands)

FY 2014-15	**TF**	**GF**	**FF**
FY 12-13 Interim Reconciliation Third Installment Payment	($1,298)	($649)	($649)
FY 12-13 Final Reconciliation	($1,011)	($505)	($506)
Total FY 2014-15	**($2,309)**	**($1,154)**	**($1,155)**

FY 2015-16	**TF**	**GF**	**FF**
FY 2013-14 Final Reconciliation	($2,309)	($1,154)	($1,155)
Total FY 2015-16	**($2,309)**	**($1,154)**	**($1,155)**

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

November 2014 Medi-Cal Estimate

OTHER ADMINISTRATION FUNDING SUMMARY

Other Administration Tab contains funding for items under both the County Administration and the Fiscal Intermediary components of the Medi-Cal Estimate (located in the Management Summary Tab). The DHCS - Health Care Option (Health Care Opt) portion of the Other Admin was formerly budgeted in the Fiscal Intermediary Tab of the Medi-Cal Estimate. Although it has been moved to the Other Administration Tab, Health Care Options continues to be budgeted in the Fiscal Intermediary component of Medi-Cal.

FY 2014-2015 ESTIMATE:	Total Funds	Federal Funds	State Funds
OTHER ADMINISTRATION			
County Administration	$1,841,153,000	$1,659,602,000	$181,551,000
Fiscal Intermediary	$173,892,000	$87,774,000	$86,118,000
Total Other Administration Tab	**$2,015,045,000**	**$1,747,376,000**	**$267,669,000**
Management Summary:			
COUNTY ADMINISTRATION	**$3,981,532,000**	**$3,207,120,000**	**$774,412,000**
Shown in Other Adminitration Tab	$1,841,153,000	$1,659,602,000	$181,551,000
Shown in County Administration Tab	$2,140,379,000	$1,547,518,000	$592,861,000
FISCAL INTERMEDIARY	**$524,242,000**	**$341,640,000**	**$182,602,000**
Shown in Other Adminitration Tab	$173,892,000	$87,774,000	$86,118,000
Shown in Fiscal Intermediary Tab	$350,350,000	$253,866,000	$96,484,000

FY 2015-2016 ESTIMATE:	Total Funds	Federal Funds	State Funds
OTHER ADMINISTRATION			
County Administration	$1,789,512,000	$1,599,742,000	$189,770,000
Fiscal Intermediary	$117,803,000	$59,628,000	$58,175,000
Total Other Administration Tab	**$1,907,315,000**	**$1,659,370,000**	**$247,945,000**
Management Summary:			
COUNTY ADMINISTRATION	**$3,617,337,000**	**$2,869,681,000**	**$747,656,000**
Shown in Other Adminitration Tab	$1,789,512,000	$1,599,742,000	$189,770,000
Shown in County Administration Tab	$1,827,825,000	$1,269,939,000	$557,886,000
FISCAL INTERMEDIARY	**$463,285,000**	**$307,507,000**	**$155,778,000**
Shown in Other Adminitration Tab	$117,803,000	$59,628,000	$58,175,000
Shown in Fiscal Intermediary Tab	$345,482,000	$247,879,000	$97,603,000

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2014-15 TOTAL FUNDS	FISCAL YEAR 2014-15 STATE FUNDS	FISCAL YEAR 2015-16 TOTAL FUNDS	FISCAL YEAR 2015-16 STATE FUNDS
	DHCS-OTHER				
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$418,611,000	$72,000	$266,440,000	$0
2	CCS CASE MANAGEMENT	$181,791,000	$71,078,600	$186,387,000	$72,608,400
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$100,518,000	$0	$103,275,000	$0
5	BTR - LIHP - ADMINISTRATIVE COSTS	$54,670,000	$0	$162,889,000	$0
6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,300	$33,718,000	$11,871,300
8	OTLICP AND MEDI-CAL ACCESS PROGRAM	$25,836,000	$9,488,100	$36,559,000	$13,466,900
9	ARRA HITECH INCENTIVE PROGRAM	$21,864,000	$1,924,000	$13,399,000	$1,154,000
10	POSTAGE & PRINTING	$20,382,000	$10,394,500	$21,032,000	$10,719,500
11	SMHS COUNTY UR & QA ADMIN	$16,856,000	$600,000	$16,093,000	$0
12	SMH MAA	$15,817,000	$0	$16,867,000	$0
13	DRUG MEDI-CAL COUNTY ADMINISTRATION	$15,082,000	$1,617,000	$17,742,000	$2,113,000
14	MIS/DSS CONTRACT	$14,000,000	$3,710,000	$12,476,000	$3,317,000
15	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000
16	DMC COUNTY UR & QA ADMIN	$9,268,000	$0	$21,626,000	$0
17	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITI	$8,433,000	$1,634,600	$4,450,000	$639,000
18	CCI-ADMINISTRATIVE COSTS	$8,202,000	$3,112,000	$6,268,000	$3,134,000
19	MEDI-CAL RECOVERY CONTRACTS	$7,004,000	$1,751,000	$5,858,000	$1,464,500
20	MEDS MODERNIZATION	$6,696,000	$669,600	$2,779,000	$660,900
21	PASRR	$6,583,000	$1,645,800	$8,150,000	$2,037,500
22	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,558,000	$1,850,500	$5,836,000	$1,943,300
23	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$5,252,000	$629,300	$8,113,000	$971,900
24	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$5,144,000	$1,286,000	$4,865,000	$1,216,300
25	NEWBORN HEARING SCREENING PROGRAM	$4,190,000	$2,095,000	$4,190,000	$2,095,000
26	SDMC SYSTEM M&O SUPPORT	$3,000,000	$1,500,000	$2,325,000	$1,162,500
27	FAMILY PACT EVALUATION	$2,861,000	$1,430,500	$2,861,000	$1,430,500

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2014-15 TOTAL FUNDS	FISCAL YEAR 2014-15 STATE FUNDS	FISCAL YEAR 2015-16 TOTAL FUNDS	FISCAL YEAR 2015-16 STATE FUNDS
	DHCS-OTHER				
28	BUSINESS RULES EXTRACTION	$2,475,000	$247,500	$835,000	$83,500
29	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	$2,326,000	$0	$1,375,000	$0
30	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,207,000	$1,103,500	$2,207,000	$1,103,500
31	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500
32	ETL DATA SOLUTION	$1,108,000	$250,800	$616,000	$125,800
33	RATE STUDIES FOR MAIC AND AAC VENDOR	$1,000,000	$500,000	$1,000,000	$500,000
34	ENCRYPTION OF PHI DATA	$995,000	$497,500	$750,000	$375,000
35	MITA	$985,000	$98,500	$152,000	$15,200
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000
37	COORDINATED CARE MANAGEMENT PILOT	$884,000	$442,000	$0	$0
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$856,000	$428,000	$856,000	$428,000
39	ACA EXPANSION ADMIN COSTS	$828,000	$414,000	$517,000	$258,500
40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$658,000	$329,000	$682,000	$341,000
42	CCT OUTREACH - ADMINISTRATIVE COSTS	$581,000	$0	$200,000	$0
43	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	$250,000	$125,000	$0	$0
44	DENTAL PAPD PROJECT MANAGER	$247,000	$61,800	$247,000	$61,800
45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$240,000	$120,000	$0	$0
47	ANNUAL EDP AUDIT CONTRACTOR	$162,000	$81,000	$162,000	$81,000
48	CCS PROGRAM PILOTS EVALUATION	$150,000	$75,000	$150,000	$75,000
49	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION	$125,000	$62,500	$125,000	$62,500
50	EPOCRATES	$107,000	$53,500	$107,000	$53,500
51	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$104,000	$26,000	$0	$0
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0
53	TAR POSTAGE	$71,000	$35,500	$66,000	$33,000
54	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$59,000	$29,500	$59,000	$29,500

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2014-15 TOTAL FUNDS	FISCAL YEAR 2014-15 STATE FUNDS	FISCAL YEAR 2015-16 TOTAL FUNDS	FISCAL YEAR 2015-16 STATE FUNDS
	DHCS-OTHER				
55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$50,000	$25,000	$0	$0
56	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	$39,000	$19,500	$0	$0
57	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$0	$0	$9,370,000	$0
	DHCS-OTHER SUBTOTAL	**$1,020,080,000**	**$139,928,300**	**$995,911,000**	**$142,175,500**
	DHCS-HEALTH CARE OPT				
58	HCO OPERATIONS	$51,560,000	$25,394,100	$38,370,000	$18,897,800
59	HCO CCI - CAL MEDICONNECT AND MLTSS	$42,175,000	$21,087,500	$16,136,000	$8,068,000
60	HCO COST REIMBURSEMENT	$34,883,000	$17,179,300	$37,646,000	$18,540,900
61	HCO ACA EXPRESS LANE ENROLLMENT CONTRACTOR CC	$16,153,000	$8,076,500	$0	$0
62	HCO ESR HOURLY REIMBURSEMENT	$13,373,000	$6,586,200	$13,715,000	$6,754,600
63	HCO - ACA ENROLLMENT CONTRACTOR COSTS	$12,633,000	$6,221,700	$10,275,000	$5,060,400
64	HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNT	$3,772,000	$1,886,000	$727,000	$363,500
65	HCO LIHP ENROLLMENT	$1,426,000	$713,000	$0	$0
66	HCO PPDs - COST SAVINGS	-$2,083,000	-$1,025,900	-$2,996,000	-$1,475,500
86	HCO ANNUAL OPEN ENROLLMENT COSTS	$0	$0	$3,930,000	$1,965,000
	DHCS-HEALTH CARE OPT SUBTOTAL	**$173,892,000**	**$86,118,300**	**$117,803,000**	**$58,174,600**
	OTHER DEPARTMENTS				
3	CALHEERS DEVELOPMENT	$128,618,000	$25,689,000	$128,618,000	$25,689,000
7	ACA OUTREACH AND ENROLLMENT COUNSELORS	$26,000,000	$13,000,000	$38,000,000	$19,000,000
41	VITAL RECORDS DATA	$605,000	$0	$883,000	$0
46	DMHC INTER-AGENCY AGREEMENT - ADMIN	$189,000	$0	$0	$0
67	PERSONAL CARE SERVICES	$223,024,000	$0	$230,866,000	$0
68	HEALTH-RELATED ACTIVITIES - CDSS	$295,794,000	$0	$251,727,000	$0
69	CDDS ADMINISTRATIVE COSTS	$41,517,000	$0	$38,505,000	$0
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$24,796,000	$0	$26,467,000	$0

OTHER ADMINISTRATION
POLICY CHANGE SUMMARY

NO.	POLICY CHANGE TITLE	FISCAL YEAR 2014-15 TOTAL FUNDS	FISCAL YEAR 2014-15 STATE FUNDS	FISCAL YEAR 2015-16 TOTAL FUNDS	FISCAL YEAR 2015-16 STATE FUNDS
	OTHER DEPARTMENTS				
71	MATERNAL AND CHILD HEALTH	$27,503,000	$0	$27,503,000	$0
72	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE	$25,143,000	$0	$25,143,000	$0
73	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COS	$10,701,000	$2,533,000	$10,718,000	$2,533,000
74	CLPP CASE MANAGEMENT SERVICES	$7,400,000	$0	$5,200,000	$0
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,463,000	$0	$3,297,000	$0
76	CHHS AGENCY HIPAA FUNDING	$1,206,000	$0	$1,215,000	$0
77	TOBACCO QUITLINE ADMINISTRATIVE SERVICES	$1,000,000	$0	$1,000,000	$0
78	VETERANS BENEFITS	$956,000	$0	$956,000	$0
79	CDPH I&E PROGRAM AND EVALUATION	$946,000	$0	$946,000	$0
80	KIT FOR NEW PARENTS	$935,000	$0	$913,000	$0
81	MEDI-CAL INPATIENT SERVICES FOR INMATES	$560,000	$0	$983,000	$0
82	MERIT SYSTEM SERVICES FOR COUNTIES	$195,000	$97,500	$195,000	$97,500
83	CDDS DENTAL SERVICES	$84,000	$84,000	$84,000	$84,000
84	PIA EYEWEAR COURIER SERVICE	$438,000	$219,000	$382,000	$191,000
	OTHER DEPARTMENTS SUBTOTAL	**$821,073,000**	**$41,622,500**	**$793,601,000**	**$47,594,500**
	GRAND TOTAL	**$2,015,045,000**	**$267,669,100**	**$1,907,315,000**	**$247,944,600**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2014-15

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2014-15 APPROPRIATION TOTAL FUNDS	2014-15 APPROPRIATION STATE FUNDS	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
		DHCS-OTHER						
1	1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$475,650,000	$0	$418,611,000	$72,000	-$57,039,000	$72,000
2	2	CCS CASE MANAGEMENT	$182,238,000	$71,288,450	$181,791,000	$71,078,600	-$447,000	-$209,850
3	4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$151,347,000	$0	$100,518,000	$0	-$50,829,000	$0
4	5	BTR - LIHP - ADMINISTRATIVE COSTS	$115,177,000	$0	$54,670,000	$0	-$60,507,000	$0
5	--	INTERIM AND FINAL COST SETTLEMENTS-SMHS	-$82,730,000	$0	$0	$0	$82,730,000	$0
6	6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,250	$33,718,000	$11,871,250	$0	$0
7	12	SMH MAA	$24,086,000	$0	$15,817,000	$0	-$8,269,000	$0
10	--	TRANSITION OF HFP TO MEDI-CAL	$15,937,000	$5,577,950	$0	$0	-$15,937,000	-$5,577,950
11	9	ARRA HITECH INCENTIVE PROGRAM	$37,475,000	$6,904,000	$21,864,000	$1,924,000	-$15,611,000	-$4,980,000
12	10	POSTAGE & PRINTING	$18,832,000	$9,519,500	$20,382,000	$10,394,500	$1,550,000	$875,000
13	39	ACA EXPANSION ADMIN COSTS	$1,155,000	$577,500	$828,000	$414,000	-$327,000	-$163,500
14	11	SMHS COUNTY UR & QA ADMIN	$18,272,000	$600,000	$16,856,000	$600,000	-$1,416,000	$0
15	14	MIS/DSS CONTRACT	$12,476,000	$3,317,000	$14,000,000	$3,710,000	$1,524,000	$393,000
16	15	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
17	18	CCI-ADMINISTRATIVE COSTS	$8,086,000	$2,551,000	$8,202,000	$3,112,000	$116,000	$561,000
18	17	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRA	$4,816,000	$679,850	$8,433,000	$1,634,600	$3,617,000	$954,750
19	23	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$8,076,000	$1,184,100	$5,252,000	$629,300	-$2,824,000	-$554,800
21	22	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,447,000	$1,800,500	$5,558,000	$1,850,500	$111,000	$50,000
22	19	MEDI-CAL RECOVERY CONTRACTS	$5,721,000	$1,430,250	$7,004,000	$1,751,000	$1,283,000	$320,750
23	37	COORDINATED CARE MANAGEMENT PILOT	$118,000	$59,000	$884,000	$442,000	$766,000	$383,000
25	21	PASRR	$8,590,000	$2,147,500	$6,583,000	$1,645,750	-$2,007,000	-$501,750
27	27	FAMILY PACT EVALUATION	$2,861,000	$1,430,500	$2,861,000	$1,430,500	$0	$0
28	29	PREVENTION OF CHRONIC DISEASE GRANT PROJEC	$2,660,000	$0	$2,326,000	$0	-$334,000	$0
29	30	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,662,000	$1,331,000	$2,207,000	$1,103,500	-$455,000	-$227,500
30	24	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$4,815,000	$1,203,750	$5,144,000	$1,286,000	$329,000	$82,250
31	26	SDMC SYSTEM M&O SUPPORT	$3,000,000	$1,500,000	$3,000,000	$1,500,000	$0	$0
32	31	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0
33	28	BUSINESS RULES EXTRACTION	$2,750,000	$1,375,000	$2,475,000	$247,500	-$275,000	-$1,127,500
35	35	MITA	$985,000	$98,500	$985,000	$98,500	$0	$0
36	36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2014-15

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2014-15 APPROPRIATION TOTAL FUNDS	2014-15 APPROPRIATION STATE FUNDS	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
		DHCS-OTHER						
37	38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$856,000	$428,000	$856,000	$428,000	$0	$0
38	34	ENCRYPTION OF PHI DATA	$750,000	$375,000	$995,000	$497,500	$245,000	$122,500
40	20	MEDS MODERNIZATION	$4,533,000	$453,300	$6,696,000	$669,600	$2,163,000	$216,300
41	40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$644,000	$322,000	$658,000	$329,000	$14,000	$7,000
44	42	CCT OUTREACH - ADMINISTRATIVE COSTS	$242,000	$0	$581,000	$0	$339,000	$0
45	32	ETL DATA SOLUTION	$325,000	$48,000	$1,108,000	$250,800	$783,000	$202,800
46	45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$240,000	$120,000	$240,000	$120,000	$0	$0
47	51	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$180,000	$45,000	$104,000	$26,000	-$76,000	-$19,000
48	44	DENTAL PAPD PROJECT MANAGER	$239,000	$119,500	$247,000	$61,750	$8,000	-$57,750
50	47	ANNUAL EDP AUDIT CONTRACTOR	$162,000	$81,000	$162,000	$81,000	$0	$0
51	50	EPOCRATES	$107,000	$53,500	$107,000	$53,500	$0	$0
52	52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$0	$0
53	53	TAR POSTAGE	$115,000	$57,500	$71,000	$35,500	-$44,000	-$22,000
55	55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$62,000	$31,000	$50,000	$25,000	-$12,000	-$6,000
56	54	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$59,000	$29,500	$59,000	$29,500	$0	$0
57	--	RECOVERY AUDIT CONTRACTOR COSTS	$12,000	$6,000	$0	$0	-$12,000	-$6,000
58	13	DRUG MEDI-CAL COUNTY ADMINISTRATION	$23,029,000	$6,620,000	$15,082,000	$1,617,000	-$7,947,000	-$5,003,000
59	25	NEWBORN HEARING SCREENING PROGRAM	$4,136,000	$2,068,000	$4,190,000	$2,095,000	$54,000	$27,000
60	33	RATE STUDIES FOR MAIC AND AAC VENDOR	$1,000,000	$500,000	$1,000,000	$500,000	$0	$0
69	8	OTLICP AND MEDI-CAL ACCESS PROGRAM	$6,130,000	$2,421,350	$25,836,000	$9,488,100	$19,706,000	$7,066,750
80	43	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	$0	$0	$250,000	$125,000	$250,000	$125,000
82	--	DENTAL FI RE-PROCUREMENT IV&V	$282,000	$70,500	$0	$0	-$282,000	-$70,500
--	16	DMC COUNTY UR & QA ADMIN	$0	$0	$9,268,000	$0	$9,268,000	$0
--	48	CCS PROGRAM PILOTS EVALUATION	$0	$0	$150,000	$75,000	$150,000	$75,000
--	49	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION	$0	$0	$125,000	$62,500	$125,000	$62,500
--	56	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	$0	$0	$39,000	$19,500	$39,000	$19,500
		DHCS-OTHER SUBTOTAL	**$1,119,560,000**	**$146,839,250**	**$1,020,080,000**	**$139,928,250**	**-$99,480,000**	**-$6,911,000**
		DHCS-HEALTH CARE OPT						
--	58	HCO OPERATIONS	$0	$0	$51,560,000	$25,394,050	$51,560,000	$25,394,050

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2014-15

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2014-15 APPROPRIATION TOTAL FUNDS	2014-15 APPROPRIATION STATE FUNDS	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
		DHCS-HEALTH CARE OPT						
--	59	HCO CCI - CAL MEDICONNECT AND MLTSS	$0	$0	$42,175,000	$21,087,500	$42,175,000	$21,087,500
--	60	HCO COST REIMBURSEMENT	$0	$0	$34,883,000	$17,179,300	$34,883,000	$17,179,300
--	61	HCO ACA EXPRESS LANE ENROLLMENT CONTRACTO	$0	$0	$16,153,000	$8,076,500	$16,153,000	$8,076,500
--	62	HCO ESR HOURLY REIMBURSEMENT	$0	$0	$13,373,000	$6,586,150	$13,373,000	$6,586,150
--	63	HCO - ACA ENROLLMENT CONTRACTOR COSTS	$0	$0	$12,633,000	$6,221,700	$12,633,000	$6,221,700
--	64	HCO- SPD TRANSITION TO MANAGED CARE RURAL C	$0	$0	$3,772,000	$1,886,000	$3,772,000	$1,886,000
--	65	HCO LIHP ENROLLMENT	$0	$0	$1,426,000	$713,000	$1,426,000	$713,000
--	66	HCO PPDs - COST SAVINGS	$0	$0	-$2,083,000	-$1,025,900	-$2,083,000	-$1,025,900
		DHCS-HEALTH CARE OPT SUBTOTAL	**$0**	**$0**	**$173,892,000**	**$86,118,300**	**$173,892,000**	**$86,118,300**
		OTHER DEPARTMENTS						
8	3	CALHEERS DEVELOPMENT	$128,618,000	$25,689,000	$128,618,000	$25,689,000	$0	$0
9	7	ACA OUTREACH AND ENROLLMENT COUNSELORS	$26,500,000	$13,250,000	$26,000,000	$13,000,000	-$500,000	-$250,000
39	81	MEDI-CAL INPATIENT SERVICES FOR INMATES	$560,000	$0	$560,000	$0	$0	$0
42	41	VITAL RECORDS DATA	$836,000	$0	$605,000	$0	-$231,000	$0
54	46	DMHC INTER-AGENCY AGREEMENT - ADMIN	$189,000	$0	$189,000	$0	$0	$0
61	67	PERSONAL CARE SERVICES	$264,886,000	$0	$223,024,000	$0	-$41,862,000	$0
62	68	HEALTH-RELATED ACTIVITIES - CDSS	$223,024,000	$0	$295,794,000	$0	$72,770,000	$0
63	69	CDDS ADMINISTRATIVE COSTS	$32,240,000	$0	$41,517,000	$0	$9,277,000	$0
64	71	MATERNAL AND CHILD HEALTH	$27,503,000	$0	$27,503,000	$0	$0	$0
65	72	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER	$25,143,000	$0	$25,143,000	$0	$0	$0
66	70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$30,928,000	$0	$24,796,000	$0	-$6,132,000	$0
67	73	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	$17,534,000	$2,533,000	$10,701,000	$2,533,000	-$6,833,000	$0
68	74	CLPP CASE MANAGEMENT SERVICES	$5,200,000	$0	$7,400,000	$0	$2,200,000	$0
70	75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,523,000	$0	$3,463,000	$0	-$60,000	$0
71	79	CDPH I&E PROGRAM AND EVALUATION	$946,000	$0	$946,000	$0	$0	$0
72	83	CDDS DENTAL SERVICES	$1,197,000	$1,197,000	$84,000	$84,000	-$1,113,000	-$1,113,000
73	80	KIT FOR NEW PARENTS	$1,017,000	$0	$935,000	$0	-$82,000	$0
74	77	TOBACCO QUITLINE ADMINISTRATIVE SERVICES	$1,000,000	$0	$1,000,000	$0	$0	$0
75	78	VETERANS BENEFITS	$956,000	$0	$956,000	$0	$0	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
NOVEMBER 2014 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2014-15

MAY PC#	NOV. PC#	POLICY CHANGE TITLE	2014-15 APPROPRIATION TOTAL FUNDS	2014-15 APPROPRIATION STATE FUNDS	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
		OTHER DEPARTMENTS						
76	76	CHHS AGENCY HIPAA FUNDING	$651,000	$0	$1,206,000	$0	$555,000	$0
77	82	MERIT SYSTEM SERVICES FOR COUNTIES	$195,000	$97,500	$195,000	$97,500	$0	$0
79	84	PIA EYEWEAR COURIER SERVICE	$440,000	$220,000	$438,000	$219,000	-$2,000	-$1,000
		OTHER DEPARTMENTS SUBTOTAL	**$793,086,000**	**$42,986,500**	**$821,073,000**	**$41,622,500**	**$27,987,000**	**-$1,364,000**
		OTHER ADMINISTRATION SUBTOTAL	**$1,912,646,000**	**$189,825,750**	**$2,015,045,000**	**$267,669,050**	**$102,399,000**	**$77,843,300**
		GRAND TOTAL COUNTY AND OTHER ADMIN.	**$3,728,180,000**	**$761,089,550**	**$4,155,424,000**	**$860,529,850**	**$427,244,000**	**$99,440,300**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

NOV. PC#	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	NOV. 2014 EST. FOR 2015-16 TOTAL FUNDS	NOV. 2014 EST. FOR 2015-16 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
	DHCS-OTHER						
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES	$418,611,000	$72,000	$266,440,000	$0	-$152,171,000	-$72,000
2	CCS CASE MANAGEMENT	$181,791,000	$71,078,600	$186,387,000	$72,608,350	$4,596,000	$1,529,750
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN	$100,518,000	$0	$103,275,000	$0	$2,757,000	$0
5	BTR - LIHP - ADMINISTRATIVE COSTS	$54,670,000	$0	$162,889,000	$0	$108,219,000	$0
6	EPSDT CASE MANAGEMENT	$33,718,000	$11,871,250	$33,718,000	$11,871,250	$0	$0
8	OTLICP AND MEDI-CAL ACCESS PROGRAM	$25,836,000	$9,488,100	$36,559,000	$13,466,850	$10,723,000	$3,978,750
9	ARRA HITECH INCENTIVE PROGRAM	$21,864,000	$1,924,000	$13,399,000	$1,154,000	-$8,465,000	-$770,000
10	POSTAGE & PRINTING	$20,382,000	$10,394,500	$21,032,000	$10,719,500	$650,000	$325,000
11	SMHS COUNTY UR & QA ADMIN	$16,856,000	$600,000	$16,093,000	$0	-$763,000	-$600,000
12	SMH MAA	$15,817,000	$0	$16,867,000	$0	$1,050,000	$0
13	DRUG MEDI-CAL COUNTY ADMINISTRATION	$15,082,000	$1,617,000	$17,742,000	$2,113,000	$2,660,000	$496,000
14	MIS/DSS CONTRACT	$14,000,000	$3,710,000	$12,476,000	$3,317,000	-$1,524,000	-$393,000
15	LITIGATION RELATED SERVICES	$9,980,000	$4,990,000	$9,980,000	$4,990,000	$0	$0
16	DMC COUNTY UR & QA ADMIN	$9,268,000	$0	$21,626,000	$0	$12,358,000	$0
17	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION	$8,433,000	$1,634,600	$4,450,000	$639,000	-$3,983,000	-$995,600
18	CCI-ADMINISTRATIVE COSTS	$8,202,000	$3,112,000	$6,268,000	$3,134,000	-$1,934,000	$22,000
19	MEDI-CAL RECOVERY CONTRACTS	$7,004,000	$1,751,000	$5,858,000	$1,464,500	-$1,146,000	-$286,500
20	MEDS MODERNIZATION	$6,696,000	$669,600	$2,779,000	$660,900	-$3,917,000	-$8,700
21	PASRR	$6,583,000	$1,645,750	$8,150,000	$2,037,500	$1,567,000	$391,750
22	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)	$5,558,000	$1,850,500	$5,836,000	$1,943,250	$278,000	$92,750
23	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT	$5,252,000	$629,300	$8,113,000	$971,900	$2,861,000	$342,600
24	HIPAA CAPITATION PAYMENT REPORTING SYSTEM	$5,144,000	$1,286,000	$4,865,000	$1,216,250	-$279,000	-$69,750
25	NEWBORN HEARING SCREENING PROGRAM	$4,190,000	$2,095,000	$4,190,000	$2,095,000	$0	$0
26	SDMC SYSTEM M&O SUPPORT	$3,000,000	$1,500,000	$2,325,000	$1,162,500	-$675,000	-$337,500
27	FAMILY PACT EVALUATION	$2,861,000	$1,430,500	$2,861,000	$1,430,500	$0	$0
28	BUSINESS RULES EXTRACTION	$2,475,000	$247,500	$835,000	$83,500	-$1,640,000	-$164,000
29	PREVENTION OF CHRONIC DISEASE GRANT PROJECT	$2,326,000	$0	$1,375,000	$0	-$951,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

NOV. PC#	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	NOV. 2014 EST. FOR 2015-16 TOTAL FUNDS	NOV. 2014 EST. FOR 2015-16 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
	DHCS-OTHER						
30	SSA COSTS FOR HEALTH COVERAGE INFO.	$2,207,000	$1,103,500	$2,207,000	$1,103,500	$0	$0
31	FAMILY PACT PROGRAM ADMIN.	$1,207,000	$603,500	$1,207,000	$603,500	$0	$0
32	ETL DATA SOLUTION	$1,108,000	$250,800	$616,000	$125,800	-$492,000	-$125,000
33	RATE STUDIES FOR MAIC AND AAC VENDOR	$1,000,000	$500,000	$1,000,000	$500,000	$0	$0
34	ENCRYPTION OF PHI DATA	$995,000	$497,500	$750,000	$375,000	-$245,000	-$122,500
35	MITA	$985,000	$98,500	$152,000	$15,200	-$833,000	-$83,300
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES	$950,000	$950,000	$950,000	$950,000	$0	$0
37	COORDINATED CARE MANAGEMENT PILOT	$884,000	$442,000	$0	$0	-$884,000	-$442,000
38	MMA - DSH ANNUAL INDEPENDENT AUDIT	$856,000	$428,000	$856,000	$428,000	$0	$0
39	ACA EXPANSION ADMIN COSTS	$828,000	$414,000	$517,000	$258,500	-$311,000	-$155,500
40	POSTAGE AND PRINTING - THIRD PARTY LIAB.	$658,000	$329,000	$682,000	$341,000	$24,000	$12,000
42	CCT OUTREACH - ADMINISTRATIVE COSTS	$581,000	$0	$200,000	$0	-$381,000	$0
43	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS	$250,000	$125,000	$0	$0	-$250,000	-$125,000
44	DENTAL PAPD PROJECT MANAGER	$247,000	$61,750	$247,000	$61,750	$0	$0
45	MEDICARE BUY-IN QUALITY REVIEW PROJECT	$240,000	$120,000	$0	$0	-$240,000	-$120,000
47	ANNUAL EDP AUDIT CONTRACTOR	$162,000	$81,000	$162,000	$81,000	$0	$0
48	CCS PROGRAM PILOTS EVALUATION	$150,000	$75,000	$150,000	$75,000	$0	$0
49	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION	$125,000	$62,500	$125,000	$62,500	$0	$0
50	EPOCRATES	$107,000	$53,500	$107,000	$53,500	$0	$0
51	MIS/DSS CONTRACT REPROCUREMENT SERVICES	$104,000	$26,000	$0	$0	-$104,000	-$26,000
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT	$100,000	$0	$100,000	$0	$0	$0
53	TAR POSTAGE	$71,000	$35,500	$66,000	$33,000	-$5,000	-$2,500
54	Q5i AUTOMATED DATA SYSTEM ACQUISTION	$59,000	$29,500	$59,000	$29,500	$0	$0
55	KATIE A. V. DIANA BONTA SPECIAL MASTER	$50,000	$25,000	$0	$0	-$50,000	-$25,000
56	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION	$39,000	$19,500	$0	$0	-$39,000	-$19,500
57	INTERIM AND FINAL COST SETTLEMENTS-SMHS	$0	$0	$9,370,000	$0	$9,370,000	$0
	DHCS-OTHER SUBTOTAL	**$1,020,080,000**	**$139,928,250**	**$995,911,000**	**$142,175,500**	**-$24,169,000**	**$2,247,250**

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

NOV. PC#	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	NOV. 2014 EST. FOR 2015-16 TOTAL FUNDS	NOV. 2014 EST. FOR 2015-16 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
	DHCS-OTHER						
	DHCS-HEALTH CARE OPT						
58	HCO OPERATIONS	$51,560,000	$25,394,050	$38,370,000	$18,897,750	-$13,190,000	-$6,496,300
59	HCO CCI - CAL MEDICONNECT AND MLTSS	$42,175,000	$21,087,500	$16,136,000	$8,068,000	-$26,039,000	-$13,019,500
60	HCO COST REIMBURSEMENT	$34,883,000	$17,179,300	$37,646,000	$18,540,850	$2,763,000	$1,361,550
61	HCO ACA EXPRESS LANE ENROLLMENT CONTRACTOF	$16,153,000	$8,076,500	$0	$0	-$16,153,000	-$8,076,500
62	HCO ESR HOURLY REIMBURSEMENT	$13,373,000	$6,586,150	$13,715,000	$6,754,600	$342,000	$168,450
63	HCO - ACA ENROLLMENT CONTRACTOR COSTS	$12,633,000	$6,221,700	$10,275,000	$5,060,400	-$2,358,000	-$1,161,300
64	HCO- SPD TRANSITION TO MANAGED CARE RURAL CC	$3,772,000	$1,886,000	$727,000	$363,500	-$3,045,000	-$1,522,500
65	HCO LIHP ENROLLMENT	$1,426,000	$713,000	$0	$0	-$1,426,000	-$713,000
66	HCO PPDs - COST SAVINGS	-$2,083,000	-$1,025,900	-$2,996,000	-$1,475,500	-$913,000	-$449,600
86	HCO ANNUAL OPEN ENROLLMENT COSTS	$0	$0	$3,930,000	$1,965,000	$3,930,000	$1,965,000
	DHCS-HEALTH CARE OPT SUBTOTAL	**$173,892,000**	**$86,118,300**	**$117,803,000**	**$58,174,600**	**-$56,089,000**	**-$27,943,700**
	OTHER DEPARTMENTS						
3	CALHEERS DEVELOPMENT	$128,618,000	$25,689,000	$128,618,000	$25,689,000	$0	$0
7	ACA OUTREACH AND ENROLLMENT COUNSELORS	$26,000,000	$13,000,000	$38,000,000	$19,000,000	$12,000,000	$6,000,000
41	VITAL RECORDS DATA	$605,000	$0	$883,000	$0	$278,000	$0
46	DMHC INTER-AGENCY AGREEMENT - ADMIN	$189,000	$0	$0	$0	-$189,000	$0
67	PERSONAL CARE SERVICES	$223,024,000	$0	$230,866,000	$0	$7,842,000	$0
68	HEALTH-RELATED ACTIVITIES - CDSS	$295,794,000	$0	$251,727,000	$0	-$44,067,000	$0
69	CDDS ADMINISTRATIVE COSTS	$41,517,000	$0	$38,505,000	$0	-$3,012,000	$0
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST	$24,796,000	$0	$26,467,000	$0	$1,671,000	$0
71	MATERNAL AND CHILD HEALTH	$27,503,000	$0	$27,503,000	$0	$0	$0
72	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER C	$25,143,000	$0	$25,143,000	$0	$0	$0
73	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT	$10,701,000	$2,533,000	$10,718,000	$2,533,000	$17,000	$0
74	CLPP CASE MANAGEMENT SERVICES	$7,400,000	$0	$5,200,000	$0	-$2,200,000	$0
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS	$3,463,000	$0	$3,297,000	$0	-$166,000	$0

COMPARISON OF FISCAL IMPACTS OF OTHER ADMINISTRATION POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2014-15 AND 2015-16

NOV. PC#	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2014-15 TOTAL FUNDS	NOV. 2014 EST. FOR 2014-15 STATE FUNDS	NOV. 2014 EST. FOR 2015-16 TOTAL FUNDS	NOV. 2014 EST. FOR 2015-16 STATE FUNDS	DIFFERENCE TOTAL FUNDS	DIFFERENCE STATE FUNDS
	OTHER DEPARTMENTS						
76	CHHS AGENCY HIPAA FUNDING	$1,206,000	$0	$1,215,000	$0	$9,000	$0
77	TOBACCO QUITLINE ADMINISTRATIVE SERVICES	$1,000,000	$0	$1,000,000	$0	$0	$0
78	VETERANS BENEFITS	$956,000	$0	$956,000	$0	$0	$0
79	CDPH I&E PROGRAM AND EVALUATION	$946,000	$0	$946,000	$0	$0	$0
80	KIT FOR NEW PARENTS	$935,000	$0	$913,000	$0	-$22,000	$0
81	MEDI-CAL INPATIENT SERVICES FOR INMATES	$560,000	$0	$983,000	$0	$423,000	$0
82	MERIT SYSTEM SERVICES FOR COUNTIES	$195,000	$97,500	$195,000	$97,500	$0	$0
83	CDDS DENTAL SERVICES	$84,000	$84,000	$84,000	$84,000	$0	$0
84	PIA EYEWEAR COURIER SERVICE	$438,000	$219,000	$382,000	$191,000	-$56,000	-$28,000
	OTHER DEPARTMENTS SUBTOTAL	**$821,073,000**	**$41,622,500**	**$793,601,000**	**$47,594,500**	**-$27,472,000**	**$5,972,000**
	OTHER ADMINISTRATION SUBTOTAL	**$2,015,045,000**	**$267,669,050**	**$1,907,315,000**	**$247,944,600**	**-$107,730,000**	**-$19,724,450**
	GRAND TOTAL COUNTY AND OTHER ADMIN.	**$4,155,424,000**	**$860,529,850**	**$3,735,140,000**	**$805,830,900**	**-$420,284,000**	**-$54,698,950**

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
1	MEDI-CAL ADMINISTRATIVE ACTIVITIES
2	CCS CASE MANAGEMENT
4	COUNTY SPECIALTY MENTAL HEALTH ADMIN
5	BTR - LIHP - ADMINISTRATIVE COSTS
6	EPSDT CASE MANAGEMENT
8	OTLICP AND MEDI-CAL ACCESS PROGRAM
9	ARRA HITECH INCENTIVE PROGRAM
10	POSTAGE & PRINTING
11	SMHS COUNTY UR & QA ADMIN
12	SMH MAA
13	DRUG MEDI-CAL COUNTY ADMINISTRATION
14	MIS/DSS CONTRACT
15	LITIGATION RELATED SERVICES
16	DMC COUNTY UR & QA ADMIN
17	CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION
18	CCI-ADMINISTRATIVE COSTS
19	MEDI-CAL RECOVERY CONTRACTS
20	MEDS MODERNIZATION
21	PASRR
22	MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)
23	CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT
24	HIPAA CAPITATION PAYMENT REPORTING SYSTEM
25	NEWBORN HEARING SCREENING PROGRAM
26	SDMC SYSTEM M&O SUPPORT
27	FAMILY PACT EVALUATION
28	BUSINESS RULES EXTRACTION
29	PREVENTION OF CHRONIC DISEASE GRANT PROJECT
30	SSA COSTS FOR HEALTH COVERAGE INFO.
31	FAMILY PACT PROGRAM ADMIN.
32	ETL DATA SOLUTION
33	RATE STUDIES FOR MAIC AND AAC VENDOR
34	ENCRYPTION OF PHI DATA
35	MITA
36	SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES
37	COORDINATED CARE MANAGEMENT PILOT
38	MMA - DSH ANNUAL INDEPENDENT AUDIT

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DHCS-OTHER
39	ACA EXPANSION ADMIN COSTS
40	POSTAGE AND PRINTING - THIRD PARTY LIAB.
42	CCT OUTREACH - ADMINISTRATIVE COSTS
43	THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS
44	DENTAL PAPD PROJECT MANAGER
45	MEDICARE BUY-IN QUALITY REVIEW PROJECT
47	ANNUAL EDP AUDIT CONTRACTOR
48	CCS PROGRAM PILOTS EVALUATION
49	MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION
50	EPOCRATES
51	MIS/DSS CONTRACT REPROCUREMENT SERVICES
52	CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT
53	TAR POSTAGE
54	Q5i AUTOMATED DATA SYSTEM ACQUISTION
55	KATIE A. V. DIANA BONTA SPECIAL MASTER
56	PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION
57	INTERIM AND FINAL COST SETTLEMENTS-SMHS
	DHCS-HEALTH CARE OPT
58	HCO OPERATIONS
59	HCO CCI - CAL MEDICONNECT AND MLTSS
60	HCO COST REIMBURSEMENT
61	HCO ACA EXPRESS LANE ENROLLMENT CONTRACTOR COSTS
62	HCO ESR HOURLY REIMBURSEMENT
63	HCO - ACA ENROLLMENT CONTRACTOR COSTS
64	HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNTIES
65	HCO LIHP ENROLLMENT
66	HCO PPDs - COST SAVINGS
86	HCO ANNUAL OPEN ENROLLMENT COSTS
	OTHER DEPARTMENTS
3	CALHEERS DEVELOPMENT
7	ACA OUTREACH AND ENROLLMENT COUNSELORS
41	VITAL RECORDS DATA
46	DMHC INTER-AGENCY AGREEMENT - ADMIN

MEDI-CAL OTHER ADMINISTRATION
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER DEPARTMENTS
67	PERSONAL CARE SERVICES
68	HEALTH-RELATED ACTIVITIES - CDSS
69	CDDS ADMINISTRATIVE COSTS
70	DEPARTMENT OF SOCIAL SERVICES ADMIN COST
71	MATERNAL AND CHILD HEALTH
72	HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE
73	FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS
74	CLPP CASE MANAGEMENT SERVICES
75	DEPARTMENT OF AGING ADMINISTRATIVE COSTS
76	CHHS AGENCY HIPAA FUNDING
77	TOBACCO QUITLINE ADMINISTRATIVE SERVICES
78	VETERANS BENEFITS
79	CDPH I&E PROGRAM AND EVALUATION
80	KIT FOR NEW PARENTS
81	MEDI-CAL INPATIENT SERVICES FOR INMATES
82	MERIT SYSTEM SERVICES FOR COUNTIES
83	CDDS DENTAL SERVICES
84	PIA EYEWEAR COURIER SERVICE

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	1
IMPLEMENTATION DATE:	7/1992
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	235

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$418,611,000	$266,440,000
STATE FUNDS	$72,000	$0
FEDERAL FUNDS	$418,539,000	$266,440,000

DESCRIPTION

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of local government agencies (LGAs), local education agencies (LEAs), and Native American Indian tribes for Medicaid administrative activities.

Authority:
AB 2377 (Chapter 147, Statutes of 1994)
AB 2780 (Chapter 310, Statutes of 1998)
SB 308 (Chapter 253, Statutes of 2003)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Activities (MAA) claiming process. The Department submits claims on behalf of LGAs, which include counties and chartered cities, to obtain FFP for Medicaid administrative activities. Many LGAs then subcontract with other organizations to perform MAA. These activities assist Medi-Cal eligible persons to learn about, enroll in, and access services of the Medi-Cal program.

AB 2780 allowed LEAs (including school districts and county offices of education), the option of claiming MAA through either their local educational consortium (one of the State's eleven administrative districts) or through the LGAs. In June 2012, CMS deferred the school based MAA (SMAA) program retroactively to October 2011. During the deferral period, schools will continue to submit invoices which will be processed as an "Early Claim" in order to meet the two-year retrospective federal claiming limitation. CMS will release deferred invoices on a flow basis as certain criteria are met and the new SMAA manual, which was conditionally approved by CMS on June 27, 2014, is implemented.

SB 308 redefined LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows tribes to participate in MAA and Targeted Case Management programs. Reimbursements for non-emergency and non-medical transportation expenditures are also available for Tribal entities.

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

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

- A redetermination of costs associated with CMAA early claims,
- An increase in TMAA contract costs,
- Updated expenditure data, and
- Claims to be made from the General Fund.

Methodology:

County Medi-Cal Administrative Activities (CMAA)

1. For CMAA cash estimate, the FY 2013-14 inflation adjusted baseline of $73,160,000 was used as the FY 2014-15 cash estimate calculation. A 5% rate increase was added to this amount to account for inflation.

   33%, or $3,541,000 out of the $10,729,000 Early Claim Placeholder, will be paid out during FY 2014-15 to account for backcasting of claims.

   $73,160,000 x 5% increase = $76,817,000 + $3,541,000 = $80,358,000

   In addition, one invoice totaling $54,000 will be paid from the General Fund since the two year Federal claiming limit expired.

   FY 2014-15: $80,358,000 + $54,000 = $80,412,000

2. The CMAA FY 2015-16 cash estimate is based on the inflation adjusted baseline of FY 2014-15, plus an additional 5% inflation factor.

   In addition, the remaining 67% Early Claim Placeholder, or $7,189,000, will be paid out during FY 2015-16 to account for backcasting of claims.

   FY 2015-16: $76,817,000 x 5% increase = $80,658,000 + $7,189,000 = $87,847,000

Tribal Medi-Cal Administrative Activities (TMAA)

3. For TMAA cash estimate, the FY 2014-15 reimbursement of $1,500,000 is based on amended contract amounts approved during FY 2013-14. The FY 2015-16 amount of $1,575,000 is based on the FY 2014-15 estimate plus a 5% inflation increase.

FY 2014-15:	$1,500,000
FY 2015-16:	$1,575,000

MEDI-CAL ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER: 1

School Medi-Cal Administrative Activities (SMAA)

4. For SMAA cash estimate, the FY 2014-15 cash estimate is based on the unpaid balance of all deferred invoices currently on placeholder, plus an estimate of the first three quarters of FY 2012-13.

   In addition, one invoice totaling $18,000 will be paid from the General Fund since the two year Federal claiming limit expired.

Unpaid deferred invoice balance		FY 2012-13 (Quarters 1-3)		GF Payment		FY 2014-15
$208,716,000	+	$127,965,000	+	$18,000	=	$336,699,000

5. The FY 2015-16 SMAA cash estimate is based on an estimate of the last quarter of FY 2012-13, plus an estimate of the first three quarters in FY 2013-14.

FY 2012-13 (Quarter 4)		FY 2013-14 (Quarters 1-3)		FY 2015-16
$42,655,000	+	$134,363,000	=	$177,018,000

6. Total MAA reimbursements FY 2014-15 and FY 2015-16 on a cash basis are:

(Dollars In Thousands)

FY 2014-15	**TF**	**FF**	**GF**
County MAA	$80,412	$80,358	$54
Tribal MAA	$1,500	$1,500	
School MAA	$336,699	$336,681	$18
Total	**$418,611**	**$418,539**	**$72**

(Dollars In Thousands)

FY 2015-16	**TF**	**FF**	**GF**
County MAA	$87,847	$87,847	
Tribal MAA	$1,575	$1,575	
School MAA	$177,018	$177,018	
Total	**$266,440**	**$266,440**	**$0**

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

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	2
IMPLEMENTATION DATE:	7/1999
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	230

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$181,791,000	$186,387,000
STATE FUNDS	$71,078,600	$72,608,350
FEDERAL FUNDS	$110,712,400	$113,778,650

DESCRIPTION

Purpose:
This policy change estimates the California Children's Services (CCS) case management cost.

Authority:
Health & Safety Code, sections 123800-123995

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

Background:
CCS county staff performs case management for clients who reside in counties with populations greater than 200,000 (independent counties). Case management includes performing all phases of program eligibility determination, evaluating the medical need for specific services, and determining appropriate providers. The state shares case management activities administered by CCS state regional office employees in Sacramento, San Francisco, and Los Angeles for counties with populations less than 200,000 (dependent counties). The Children's Medical Services Net (CMS Net) automated system is utilized by the CCS Medi-Cal program to assure case management activities.

Effective January 1, 2013, the Healthy Family Program (HFP) ceased to enroll new subscribers and began transitioning HFP subscribers into the Medi-Cal Optional Targeted Low Income Children's Program (OTLICP). The transition of HFP subscribers to OTLICP completed in November 2013.

A portion of CCS case management transitioned into the Health Plan of San Mateo (HPSM) beginning April 2013.

Reason for Change from Prior Year:
The CMS Net amount has been updated.

Methodology:
1. The county administrative estimate for the budget year is updated every May based on additional data collected.

2. For FY 2014-15, the CCS case management costs are based on budgeted county expenditures of $149,194,000 in the May 2014 Estimate.

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

For FY 2015-16, caseload is expected to increase 1.77% from FY 2014-15 to FY 2015-16.

$149,194,000 x (1 + 1.77%) = $151,835,000

3. For FY 2014-15, Pediatric Palliative Care (PPC) Nurse Liaison costs are $751,000.

4. For FY 2015-16, PPC Nurse Liaison costs are estimated as follows:
   - Each county will have one medical professional (nurse) and one support staff (clerk) for every 25 palliative care participants.
   - The annual cost is $200,000 per one nurse and one clerk pair.
   - Of the nine original counties, eight have 25 or less palliative care participants and one county has between 25 and 50 palliative care participants.
   - PPC caseload is expanding to seven additional counties, one every two months, through FY 2015-16. Each county will have 17-18 members enrolled.

     $200,000 x 8 (counties) = $1,600,000
     $200,000 x 1 (county) x 2 (pairs of nurse/clerk) = $400,000
     $1,600,000 + $400,000 = $2,000,000 PPC Nurse Liaison costs for original counties.
     $2,000,000 + $717,000 (expansion Nurse Liaison costs) = $2,717,000

5. County data processing costs associated with CMS Net for CCS Medi-Cal are estimated to be $2,389,000 in FY 2014-15 and $2,383,000 in FY 2015-16.

6. Medi-Cal OTLICP costs consist of the following:

	FY 2014-15	FY 2015-16
County Administration:	$31,517,000	$31,517,000

7. County data processing costs associated with CMS Net for OTLICP are estimated to be $374,000 in FY 2014-15 and $369,000 in FY 2015-16.

8. HPSM begins operation in April 2013 and receives monthly payments beginning May 2013. Payments to HPSM will be applied against CCS Case Management. All June payments will be made in July. Both CY and BY payments include a net 12 months of cost.

FY 2014-15:	($2,434,000)
FY 2015-16:	($2,434,000)

9. AB 1745 requires the Department to conduct a waiver pilot project to determine whether PPC should be provided as a benefit under the Medi-Cal program. These expenditures have been rolled into the CCS case management costs.

FY 2014-15 CCS Medi-Cal	**TF**	**GF**	**FF**	**Reimburse-ment***
CCS Case Management	$149,194,000	$58,924,000	$90,270,000	
Pediatric Palliative Care	$751,000	$188,000	$563,000	
CMS Net	$2,389,000	$1,195,000	$1,195,000	
	$152,334,000	$60,307,000	$92,028,000	$0

CCS CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 2

CCS Medi-Cal/OTLICP	TF	GF	FF	Reimburse-ment*
CCS Case Management	$31,517,000	$5,515,000	$20,486,000	$5,515,000
CMS Net	$374,000	$131,000	$243,000	
	$31,891,000	$5,646,000	$20,729,000	$5,515,000
Health Plan of San Mateo	($2,434,000)	($1,217,000)	($1,217,000)	
Total	**$181,791,000**	**$64,736,000**	**$111,540,000**	**$5,515,000**

FY 2015-16 CCS Medi-Cal	TF	GF	FF	Reimburse-ment*
CCS Case Management	$151,835,000	$59,967,000	$91,868,000	
Pediatric Palliative Care	$2,717,000	$679,000	$2,038,000	
CMS Net	$2,383,000	$1,192,000	$1,192,000	
	$156,935,000	$61,838,000	$95,098,000	$0
CCS Medi-Cal/OTLICP				
CCS Case Management	$31,517,000	$5,515,000	$20,486,000	$5,515,000
CMS Net	$369,000	$129,000	$240,000	
	$31,886,000	$5,644,000	$20,726,000	$5,515,000
Health Plan of San Mateo	($2,434,000)	($1,217,000)	($1,217,000)	$0
Total**	**$186,387,000**	**$66,265,000**	**$114,607,000**	**$5,515,000**

**Amounts differ due to rounding.

Funding:

(Dollars in Thousands)

FY 2014-15	TF	GF	FF	County
50% Title XIX / 50% GF (4260-101-0001/0890)	$86,458	$43,229	$43,229	
75% Title XIX / 25% GF (4260-101-0001/0890)	$63,442	$15,861	$47,582	
65% Title XXI / 35% GF (4260-113-0001/0890)	$26,376	$5,646	$20,729	
100% Reimbursement GF (4260-610-0995)*	$5,515	$0	$0	$5,515
Total	$181,791	$64,736	$111,540	$5,515

FY 2015-16	TF	GF	FF	County
50% Title XIX / 50% GF (4260-101-0001/0890)	$87,983	$43,991	$43,991	
75% Title XIX / 25% GF (4260-101-0001/0890)	$66,518	$16,630	$49,889	
65% Title XXI / 35% GF (4260-113-0001/0890)	$26,371	$5,645	$20,726	
100% Reimbursement GF (4260-610-0995)*	$5,515	$0	$0	$5,515
Total**	$186,387	$66,266	$114,606	$5,515

**Amounts differ due to rounding.

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	3
IMPLEMENTATION DATE:	6/2012
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1679

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$128,618,000	$128,618,000
STATE FUNDS	$25,689,000	$25,689,000
FEDERAL FUNDS	$102,929,000	$102,929,000

DESCRIPTION

Purpose:
This policy change estimates the cost for developing, implementing, ongoing maintenance, and operations of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). This policy change also includes the cost for contractors and staff to integrate the Medi-Cal Eligibility Data System (MEDS) into the CalHEERS.

Authority:
Affordable Care Act (ACA) of 2010
Interagency Agreement
Contract

Interdependent Policy Changes:
Not Applicable

Background:
The ACA mandates the establishment of health insurance exchanges, in California known as Covered California to provide competitive health care coverage for individuals and small employers. As required by ACA, states will use Covered California's new CalHEERs to determine an applicant's eligibility for subsidized coverage. In creating this "one-stop-shop" experience, states are required to use a single, streamlined application for the applicants to apply for all applicable health subsidy programs. The application may be filed online, in person, by mail, by telephone, or with the Medicaid and Children's Health Insurance Program agency. To meet this requirement, the Department and Covered California have formed a partnership to acquire a Systems Integrator to design and implement the CalHEERS as the business solution that will allow the required one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.

CalHEERS was programmed to provide Modified Adjusted Gross Income eligibility determinations for individuals seeking coverage through Covered California and Medi-Cal. In order to provide seamless integration with the new CalHEERS system, the Department established and designed the implementation of technology solutions for ongoing maintenance of MEDS changes and integration with CalHEERS.

ACA offers additional enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required health benefit exchanges. The Department will also receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related system changes needed to interface with the CalHEERS. Medi-Cal's associated cost for the one-time development and implementation of CalHEERS is 10/90 FFP and 35/65 FFP. CalHEERS ongoing Operations and Maintenance (O&M)

CALHEERS DEVELOPMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 3

cost is 25/75 FFP and 35/65 FFP. CalHEERS' costs are shared between Covered California and Medi-Cal. Covered California will reimburse the Department for their share.

Reason for Change from Prior Estimate:
As the CalHEERS Project executes detailed D&I activities, necessary budget revisions have been made to respond to slower-than-planned ramp up of the project, more precise estimates from our interface partners, and increased need for systems integrator change hours. In addition, there is a later expected completion date to better meet the business needs.

Methodology:

1. Contractors began development and implementation (D&I) work in July 2012. Assume contractors will begin maintenance and operations (M&O) in January 2015.

2. The consultants began D&I work on the MEDS Interface project in November 2012. Payments began in December 2012.

3. FY 2014-15 and 2015-16, costs will be shared based on estimated enrollment for shared costs at a rate of 20% Covered California and 80% to the Department. Costs directly attributable to the Department will be 100%.

4. In FY 2014-15 and 2015-16, costs incurred are for CalHEERS' D&I and M&O.
   The design, development, and implementation period is eligible for:
   - 86% at 90% federal reimbursement
   - 14% at 65% federal reimbursement

   The maintenance and operations period is eligible for:
   - 86% at 90% federal reimbursement
   - 14% at 65% federal reimbursement

FY 2014-15:	TF	GF	FF	Reimbursements
Title XIX (75% FF / 25% GF)	$49,984,000	$11,654,000	$37,312,000	$1,018,000
Title XIX (90% FF / 10% GF)	$61,124,000	$4,538,000	$54,242,000	$2,344,000
Title XXI (65% FF / 35% GF)	$17,510,000	$6,134,000	$11,376,000	$0
Total	**$128,618,000**	**$22,326,000**	**$102,930,000**	**$3,362,000**

FY 2015-16:	TF	GF	FF	Reimbursements
Title XIX (75% FF / 25% GF)	$49,984,000	$11,654,000	$37,312,000	$1,018,000
Title XIX (90% FF / 10% GF)	$61,124,000	$4,538,000	$54,242,000	$2,344,000
Title XXI (65% FF / 35% GF)	$17,510,000	$6,134,000	$11,376,000	$0
Total	**$128,618,000**	**$22,326,000**	**$102,930,000**	**$3,362,000**

Funding:
65% Title XXI / 35% GF (4260-113-0001/0890)
75% Title XIX / 25 % GF (4260-101-0001/0890)
90% Title XIX / 10 % GF (4260-101-0001/0890)

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	4
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1721

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$100,518,000	$103,275,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$100,518,000	$103,275,000

DESCRIPTION

Purpose:
This policy change estimates the county administrative costs for the Specialty Mental Health Medi-Cal Waiver, Medicaid Children's Health Insurance Program, and Healthy Families Program administered by county mental health departments.

Authority:
Welfare & Institutions Code 14711(c)

Interdependent Policy Changes:
Not Applicable

Background:
Counties may obtain federal reimbursement for certain costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.

Reason for Change from Prior Estimate:
Medi-Cal administrative costs for specialty mental health services (SMHS) decreased based on revised payment lag factors.

Methodology:
1. Mental Health administration costs are based on historical trends. Below are the costs on an accrual basis for Medi-Cal (MC), Healthy Families Program (HFP), and Medicaid Children's Health Insurance Program (M-CHIP). Due to the transition of HFP to Medi-Cal, the HFP costs will entirely shift to M-CHIP in FY 2014-15.

(Dollars In Thousands)

Fiscal Year	MC	HFP	M-CHIP	Total
FY 2012-13	$190,160	$2,009	$2,440	$194,609
FY 2013-14	$194,286	$1,026	$3,520	$198,832
FY 2014-15	$199,629	$0	$4,671	$204,300
FY 2015-16	$205,538	$0	$4,809	$210,347

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4

(Dollars In Thousands)

Fiscal Year	Total	FF	County
FY 2012-13	$194,609	$97,972	$96,637
FY 2013-14	$198,832	$100,098	$98,734
FY 2014-15	$204,300	$102,851	$101,449
FY 2015-16	$210,347	$105,895	$104,452

2. Based on historical claims received, assume 23% of each fiscal year claims will be paid in the year the services occur. Assume 67% is paid in the following year and an additional 10% in the third year.

(Dollars In Thousands)

Fiscal Year	Accrual	FY 2013-14	FY 2014-15	FY 2015-16
MC	$190,160	$127,407	$19,016	$0
HFP	$2,009	$1,346	$201	$0
M-CHIP	$2,440	$1,635	$244	$0
FY 2012-13	$194,609	$130,388	$19,461	$0
MC	$194,286	$44,686	$130,172	$19,429
HFP	$1,026	$236	$687	$103
M-CHIP	$3,519	$809	$2,358	$352
FY 2013-14	$198,831	$45,731	$133,217	$19,884
MC	$199,629	$0	$45,915	$133,751
M-CHIP	$4,671	$0	$1,074	$3,130
FY 2014-15	$204,300	$0	$46,989	$136,881
MC	$205,538	$0	$0	$47,274
M-CHIP	$4,809	$0	$0	$1,106
FY 2015-16	$210,347	$0	$0	$48,380

3. Mental Health administration costs are shared between federal funds (FF) and county funds. HFP and M-CHIP claims are eligible for federal reimbursement of 65%. MC claims are eligible for 50% federal reimbursement.

(Dollars In Thousands)

	FY 2014-15			FY 2015-16		
Claims	TF	FF	County	TF	FF	County
MC	$195,103	$97,551	$97,551	$200,454	$100,227	$100,227
HFP*	$889	$578	$311	$103	$67	$36
M-CHIP*	$3,676	$2,389	$1,287	$4,587	$2,982	$1,606
Total	$199,667	**$100,518**	$99,149	$205,144	**$103,275**	$101,869

COUNTY SPECIALTY MENTAL HEALTH ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 4

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

BTR - LIHP - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	5
IMPLEMENTATION DATE:	7/2012
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	1589

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$54,670,000	$162,889,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$54,670,000	$162,889,000

DESCRIPTION

Purpose:
This policy change estimates federal funds for the administrative costs associated with the Low Income Health Program (LIHP) under the California Bridge to Reform (BTR) Demonstration.

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration

Interdependent Policy Changes:
Not Applicable

Background:
The LIHP, effective November 1, 2010 through December 31, 2013, consisted of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE covered eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI covered those with family incomes above 133% through 200% of the FPL. Both were statewide county elective programs. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) which was extended until October 31, 2010. AB 342 and AB 1066 authorized local LIHPs to provide health care services to eligible individuals.

The Centers for Medicare and Medicaid Services (CMS) provided uncapped federal funds to the local LIHPs at an amount equal to the regular Federal Medical Assistance Percentage (50%) for their administrative costs associated with the start-up, implementation, and close out administration of their approved LIHPs. The Department will use Certified Public Expenditures (CPEs) of the local government administrative costs to draw down federal funds and will distribute these funds to the local governments. The Department used the HCCI administrative activities cost claiming protocol for the HCCI under the MH/UCD, as the basis for providing reimbursement for the allowable administrative costs incurred from November 1, 2010 through September 30, 2011, as permitted by the Special Terms and Conditions for the section 1115(a) BTR Demonstration. The Department received CMS approval of the BTR-LIHP administrative cost claiming protocol and time study on December 12, 2013.

Reason for Change from Prior Estimate:
The change is due to a delay in federal approval, which delayed LIHP Administrative claiming.

Methodology:
1. Administrative payments will be based on the CMS approved administrative cost claiming protocol and time study.

BTR - LIHP - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 5

2. Invoices for administrative payments for FY 2011-12, FY 2012-13, and FY 2013-14 will be processed in FY 2014-15 and FY 2015-16.

3. Estimates for start-up costs are based on historical data and will be processed in FY 2014-15 and FY 2015-16.

4. Estimated administrative costs are expected to be as follows:

(Dollars in Thousands)	LIHP-MCE	Total FFP
FY 2014-15		
FY 2011-12	$3,566	$3,566
FY 2013-14	$51,104	$51,104
Total FY 2014-15	**$54,670**	**$54,670**
FY 2015-16		
FY 2011-12	$3,566	$3,566
FY 2012-13	$79,661	$79,661
FY 2013-14	$79,661	$79,661
Total FY 2015-16*	**$162,889**	**$162,889**

*Total may differ due to rounding.

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

EPSDT CASE MANAGEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	6
IMPLEMENTATION DATE:	7/1996
ANALYST:	Peter Bjorkman
FISCAL REFERENCE NUMBER:	229

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$33,718,000	$33,718,000
STATE FUNDS	$11,871,250	$11,871,250
FEDERAL FUNDS	$21,846,750	$21,846,750

DESCRIPTION

Purpose:
This policy change estimates Medi-Cal's Early and Periodic Screening Diagnosis and Treatment (EPSDT) Case Management allocation.

Authority:
Health & Safety Code 124075(a)
Welfare & Institutions Code 10507

Interdependent Policy Changes:
Not Applicable

Background:
Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.

The EPSDT Case Management budget is allocated to individual counties and controlled on an accrual basis.

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

Methodology:
1. The set allocation amount is $33,718,000 ($11,871,250 GF) annually based on a formula calculated by the Child Health and Disability Prevention program.

	TF	GF	FFP
Allocation	**$33,718,000**	**$11,871,000**	**$21,847,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% Title XIX (4260-101-0890)

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER:	7
IMPLEMENTATION DATE:	7/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1820

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$26,000,000	$38,000,000
STATE FUNDS	$13,000,000	$19,000,000
FEDERAL FUNDS	$13,000,000	$19,000,000

DESCRIPTION

Purpose:
This policy change estimates the costs for outreach, enrollment and renewal activities related to targeted Medi-Cal populations who are eligible as result of the Affordable Care Act (ACA).

Authority:
SB 101 (Chapter 361, Statutes of 2013)
SB 18 (Chapter 551, Statutes of 2014)

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 result of both the ACA optional and ACA mandatory expansions.

The Department partnered with Covered California to certify enrollment counselors and provide outreach, enrollment, renewal assistance and marketing activities related to the ACA. This policy change estimates the costs for the outreach, enrollment and renewal assistance for targeted Medi-Cal populations. Also included in this policy change are costs to compensate Medi-Cal enrollment counselors. There will be special emphasis on targeting of the following populations:

1) Persons with mental health disorder needs;
2) Persons with substance use disorder needs;
3) Persons who are homeless;
4) Young men of color;
5) Persons who are in county jail, in state prison, on state parole, on county probation, or under post release community supervision;
6) Families of mixed-immigration status; and,
7) Persons with limited English proficiency.

The Department established a special Healthcare Outreach and Medi-Cal Enrollment Account within a Special Deposit Fund to collect and allocate public or private grants to fund these activities.

ACA OUTREACH AND ENROLLMENT COUNSELORS

OTHER ADMIN. POLICY CHANGE NUMBER: 7

Reason for Change from Prior Estimate:
FY 2013-14 funding has shifted to FY 2014-15 and additional funding related to renewal assistance activities has been added.

Methodology:

1) The Department estimates $65,000,000 will be spent on these activities in FY 2014-15 and FY 2015-16.

2) Per SB 101 (Chapter 361, Statutes of 2013) Section 5(d), the Department has authority to expend in aggregate up to $500,000 to administer the activities budgeted in this policy change. The Department has included the administrative funding in the Department's support budget (4260-501-0942 (285)).

3) The funds will be spent as follows:

(Dollars in Thousands)

FY 2014-15	TF	Special Fund	FF
Enrollment Counselors	$14,000	$7,000	$7,000
Outreach and Enrollment	$12,500	$6,250	$6,250
Subtotal	$26,500	$13,250	$13,250
Support Adjustment (4260-501-0942)	($500)	($250)	($250)
Total	**$26,000**	**$13,000**	**$13,000**

FY 2015-16	TF	Special Fund	FF
Enrollment Counselors	$14,000	$7,000	$7,000
Outreach and Enrollment	$12,500	$6,250	$6,250
Renewal Assistance	$12,000	$6,000	$6,000
Subtotal	$38,500	$19,250	$19,250
Support Adjustment (4260-501-0942)	($500)	($250)	($250)
Total	**$38,000**	**$19,000**	**$19,000**

Funding:
50% Title XIX FFP (4260-101-0890)
50% Healthcare Outreach Fund (4260-601-0942285)

OTLICP AND MEDI-CAL ACCESS PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	8
IMPLEMENTATION DATE:	1/2013
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1748

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$25,836,000	$36,559,000
STATE FUNDS	$9,488,100	$13,466,850
FEDERAL FUNDS	$16,347,900	$23,092,150

DESCRIPTION

Purpose:
This policy change estimates the contract costs and other administrative vendor services for the Optional Targeted Low Income Children Program (OTLICP) and Medi-Cal Access program.

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

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB) contracted with MAXIMUS as Single Point of Entry (SPE) application and other administrative vendor services for the Healthy Families Program (HFP), Access for Infants and Mothers (AIM) and Child Health and Disability Prevention (CHDP) Gateway.

Healthy Families Program (HFP) subscribers began transitioning into Medi-Cal as OTLICP starting January 1, 2013. Completed applications were sent to the SPE for screening and forwarded to the county welfare departments (CWD) for a Medi-Cal determination for the children's percent programs or to the new OTLICP.

The AIM infants above 250% of poverty level began transitioning into Medi-Cal beginning November 1, 2013. The transition ended on February 1, 2014. The AIM mothers began transitioning into Medi-Cal starting July 1, 2014. AIM is now referred to as the Medi-Cal Access Program.

Beginning January 1, 2014, the Department instructed MAXIMUS to close out SPE for HFP and CHDP Gateway and refer applicants to the application portal and toll-free line at Covered California. The shutdown process was completed in FY 2013-14.

As of July 1, 2014, all MRMIB programs, including the MAXIMUS contract, transitioned to the Department. For FY 2014-15 and FY 2015-16, MAXIMUS will provide administrative vendor services for Medi-Cal Access Program and OTLICP. Due to the number of applications still available in the community, the HFP applications continue to be received by MAXIMUS and then forwarded to the appropriate CWD for a determination without the benefit of screening for accelerated enrollment.

Administrative vendor services include costs for the following services; applications processing, call minute rate per minute, transaction forwarding fee, processing letters and notices and printing and courier fees. FY 2014-15 and FY 2015-16 costs also includes implementation costs to automate system interfaces between MAXIMUS and the Department.

OTLICP AND MEDI-CAL ACCESS PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Reason for Change from Prior Estimate:

- MAXIMUS' contract cost, which was previously included in Other Administrative policy change Transition of HFP to Medi-Cal, is now included in this policy change.
- Administrative costs for AIM Infants, which was previously included in policy change AIM Linked Infants 250-300% FPL, is now included in this policy change.
- Administrative costs for AIM Mothers, which was previously included in policy change AIM Linked Mothers 200-300% FPL, is now included in this policy change.
- Caseload for AIM Infants and Mothers administrative costs has changed from the prior estimate.

Methodology:

1. This estimate is based on an average of actual usage and processing of the applications, postage, and vendor contract rates and services.

2. Contract costs for two Medi-Cal programs are eligible for Title XXI 65/35 FMAP, Title XIX 50/50 FMAP and Skilled Professional 75/25 FMAP.

3. Administrative vendor services costs for the two Medi-Cal programs are eligible for Title XIX 50/50 FMAP and Title XXI 65/35 FMAP.

FY 2014-15	TF	GF	FF
Contract Costs	$15,937,000	$5,578,000	$10,359,000
Applications Processing	$1,810,000	$715,000	$1,095,000
Letters and Notices	$1,294,000	$511,000	$783,000
Printing and Courier Fees	$134,000	$53,000	$81,000
Call Minute Rate per Minute	$1,643,000	$649,000	$994,000
Transaction Forwarding Fee	$789,000	$312,000	$477,000
Implementation Costs	$4,229,000	$1,671,000	$2,558,000
Total	**$25,836,000**	**$9,489,000**	**$16,347,000**

FY 2015-16	TF	GF	FF
Contract Costs	$22,200,000	$7,795,000	$14,405,000
Applications Processing	$2,865,000	$1,132,000	$1,733,000
Letters and Notices	$696,000	$275,000	$421,000
Printing and Courier Fees	$111,000	$44,000	$67,000
Call Minute Rate per Minute	$3,852,000	$1,522,000	$2,330,000
Transaction Forwarding Fee	$875,000	$346,000	$529,000
Implementation Costs	$5,960,000	$2,355,000	$3,605,000
Total	**$36,559,000**	**$13,469,000**	**$23,090,000**

OTLICP AND MEDI-CAL ACCESS PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 8

Funding:

FY 2014-15	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$2,970,000	$1,485,000	$1,485,000
65% Title XXI / 35% GF (4260-113-0890/0001)	$22,866,000	$8,003,000	$14,863,000
Total	$25,836,000	$9,488,000	$16,348,000

FY 2015-16	**TF**	**GF**	**FF**
50% Title XIX / 50% GF (4260-101-0890/0001)	$4,808,000	$2,404,000	$2,404,000
65% Title XXI / 35% GF (4260-113-0890/0001)	$31,251,000	$10,938,000	$20,313,000
75% Skilled Professional FMAP/ 25% GF	$500,000	$125,000	$375,000
Total	$36,559,000	$13,467,000	$23,092,000

*Totals may differ due to rounding

ARRA HITECH INCENTIVE PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	9
IMPLEMENTATION DATE:	7/2010
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1370

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$21,864,000	$13,399,000
STATE FUNDS	$1,924,000	$1,154,000
FEDERAL FUNDS	$19,940,000	$12,245,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs associated with the advancement of the Health Information Technology for Economic and Clinical Health (HITECH) Incentive Act under the American Recovery and Reinvestment Act (ARRA) of 2009.

Authority:
ARRA of 2009
SB 945 (Chapter 433, Statutes of 2011)
AB 1467 (Chapter 23, Statutes of 2012)
SB 870 (Chapter 40, SEC 15, Budget Act of 2014)
Welfare & Institutions Code, Sections 14046.1 and 14046.7

Interdependent Policy Changes:
FI Estimate
PC 173 ARRA HITECH Provider Payments

Background:
The HITECH Act, a component of the ARRA, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must adopt, implement, or upgrade (AIU) and meaningfully use certified Electronic Health Records (EHR) technology in accordance with the HITECH Act requirements. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011. The payments to the providers under HITECH are budgeted in the ARRA HITECH – Provider Payments policy change. The HITECH Act pays provider incentive payments at 100% federal funds (FF).

In 2011, SB 945 authorized the Department to establish and administer the ARRA HITECH Incentive Program only to the extent that FF was available and there would be no General Fund (GF) impact. In 2012, AB 1467 provided that no more than $200,000 from the GF may be used annually for state administrative costs associated with the program.

SB 870 appropriates $3,750,000 from the Major Risk Medical Insurance Fund (MRMIF) to the Department for purposes of an EHR provider technical assistance program in accordance with the State Medicaid Health Information Technology Plan (SMHP) as specified in Section 14046.1 of the Welfare and Institutions Code. The appropriated sum amounts to a ten percent match for the $37,500,000 allocation from CMS to procure vendors for the statewide EHR provider technical assistance program for eligible providers.

ARRA HITECH INCENTIVE PROGRAM

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The Department received approval of the SMHP and Implementation Advance Planning Document (IAPD) on September 30, 2011. The SMHP and IAPD authorized implementation of the EHR Incentive Program, which occurred on October 3, 2011. CMS approved an IAPD Update (IAPD-U) on September 9, 2013. An update to the IAPD was submitted to CMS on July 3, 2014 for approval. The new IAPDU requests additional funds for meaningful use (MU) measures including immunization registries, electronic lab reporting, and provider technical assistance.

The Department is required by CMS to assess the current usage of and barriers to EHR adoption by providers and continued maintenance of the Incentive Program; multiple contractors are required in order to complete the assessments. Also, the Department, in collaboration with a wide variety of stakeholder organizations, developed a Medi-Cal EHR Incentive Program Project Book that identifies a series of projects to help facilitate the ongoing development and evaluation of the program.

The Medi-Cal Fiscal Intermediary (FI), Xerox State Healthcare, LLC completed the development of an enrollment and eligibility portal for Medi-Cal professionals and hospitals. SB 945 limitations did not apply to the Xerox projects as the funding for these projects were approved as part of the FI budget prior to the passage of SB 945. The costs of the Xerox projects, which are eligible for FFP, are budgeted in the FI Estimate as an optional contractual service. These costs include maintenance and operation and the development of additional functionalities.

The Department and the California Department of Public Health (CDPH) have partnered on a project to upgrade the California Immunization Registry (CAIR). The CAIR 2.0 project will transform the existing CAIR infrastructure and software to fully support MU data exchange among EHRs, leveraging enhanced federal dollars.

In addition to CAIR 2.0, the Department will administer the following projects:

- The Department and CDPH will partner on the California Reportable Disease Information Exchange (CalREDIE) project to implement a computer application system for web-based disease reporting and surveillance. The CalREDIE project will improve the efficiency of surveillance activities and the early detection of public health events through the collection of more complete and timely surveillance information on a statewide basis.

- The Department will issue a Request for Proposal for services providing technical assistance to providers preparing to meet AIU and/or MU objectives. The need for assistance is related to the discontinuance of the Regional Extension Centers which currently provide technical support to providers participating in the Medi-Cal EHR Incentive Program.

- The Department will contract with the University of California, San Francisco (UCSF) under an Interagency Agreement to conduct a qualitative Ambulatory Care Study which will build on prior work performed by the contract Investigators. The study will fill important gaps in information necessary for policymakers and providers using EHR in California.

- The Department has contracted with UCSF to conduct periodic surveys over the course of the EHR Incentive Program which were required to refine the initial landscape assessment and to document activities currently underway or in the planning phase. The California Physicians' Use of EHR surveys were completed in March 2014 and will be used to facilitate Health Information Exchange and EHR adoption for Medi-Cal.

- The Department will collaborate with the California Health and Human Services (CHHS) and

ARRA HITECH INCENTIVE PROGRAM

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the California Office of Health Information Integrity to facilitate the California Health Information Technology (HIT)/Health Information Exchange (HIE) Stakeholder Summit (Summit) in May 2015. The Summit will help stakeholders understand how individuals and organizations fit into HIE in California; enable stakeholders to learn about available resources for planning clinical and administrative integration; and provide a forum for stakeholders to have a voice in shaping the future of HIE in California. A wrap up event will follow The Summit to address the future of HIE activity and sustainability in California.

Reason for Change from Prior Estimate:
For FY 2014-15, the amount budgeted has been reduced as a result of updates for current projects and the addition of a new project, the California HIT/HIE Stakeholder Summit. Project amounts have changed due to changes in project schedules; the amount for the CalREDIE project has increased, while the amount for the Provider Technical Assistance project has decreased. Additionally, the Ambulatory Care Study has a contract extension and is included in FY 2014-15 for the remaining amount.

Methodology:

1. The ARRA HITECH Incentive Program is eligible for Title XIX 90% FF.

2. For the CAIR 2.0 and CalREDIE projects, the 10% non-federal share is budgeted by CDPH. This policy change budgets the Title XIX 90% FF that will be provided to CDPH for the CAIR 2.0 and CalREDIE contracts through an interagency agreement.

3. The Provider Technical Assistance project is eligible for Title XIX 90% FF. In FY 2014-15 and FY 2015-16, the 10% non-federal share will be provided by the MRMIF.

4. In FY 2014-15, the 10% non-federal share for the Ambulatory Care Study will be funded by UCSF.

5. For the California HIT/HIE Stakeholder Summit, the 10% non-federal share is budgeted by CHHS. This policy change budgets the Title XIX 90% FF that will be provided to CHHS for the California HIT/HIE Stakeholder Summit contract through an interagency agreement.

6. In FY 2014-15 and FY 2015-16, the 10% non-federal share for the other projects will be provided by outside entities.

7. Xerox projects are eligible for ARRA HITECH funding under the FI contract.

FY 2014-15:	**TF**	**Reimbursement**	**SF**	**FF**
CAIR 2.0	$1,554,000	$0	$0	$1,554,000
CalREDIE	$755,000	$0	$0	$755,000
Provider Technical Assist. (90% FF/10% SF)*	$17,500,000	$0	$1,750,000	$15,750,000
Ambulatory Care Study (90% FF/10% GF)	$204,000	$20,000	$0	$184,000
California HIT/HIE Summit	$316,000	$0	$0	$316,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total	**$21,864,000**	**$174,000**	**$1,750,000**	**$19,940,000**
	TF	**GF**	**SF**	**FF**
Xerox projects (In FI Estimate)	$800,000	$80,000	$0	$720,000
Total FY 2014-15	$22,664,000	$254,000	$1,750,000	$20,660,000

ARRA HITECH INCENTIVE PROGRAM

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FY 2015-16:	TF	Reimbursement	SF	FF
CAIR 2.0	$1,071,000	$0	$0	$1,071,000
CalREDIE	$793,000	$0	$0	$793,000
Provider Technical Assist. (90% FF/10% SF)*	$10,000,000	$0	$1,000,000	$9,000,000
Other projects (90% FF/10% GF)	$1,535,000	$154,000	$0	$1,381,000
Total	**$13,399,000**	**$154,000**	**$1,000,000**	**$12,245,000**

	TF	GF	SF	FF
Xerox projects (In FI Estimate)	$800,000	$80,000	$0	$720,000
Total FY 2015-16	$14,199,000	$234,000	$1,000,000	$12,965,000

Funding:
100% Title XIX (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Reimbursement (4260-602-0313)*

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER:	10
IMPLEMENTATION DATE:	7/1993
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	231

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$20,382,000	$21,032,000
STATE FUNDS	$10,394,500	$10,719,500
FEDERAL FUNDS	$9,987,500	$10,312,500

DESCRIPTION

Purpose:
This policy change budgets postage and printing costs for items sent to or used by Medi-Cal beneficiaries.

Authority:
Welfare & Institutions Code 14007.71

Interdependent Policy Changes:
Not Applicable

Background:
Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees and to existing beneficiaries at least every 3 years. Postage and printing costs for the HIPAA NPP, Quarterly JvR ("Your Fair Hearing Rights"), Incarceration Verification Program (IVP), Earned Income Tax Credit (EITC), and Public Assistance Reporting Information System (PARIS) are included in this item.

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are 100% general fund (GF).

Reason for Changes from Prior Estimate:
Higher FY 2014-15 costs were a result of the increased mailing costs due to caseload growth.

Methodology:

1. Estimated costs were provided by the Medi-Cal Eligibility Division (MCED).

POSTAGE & PRINTING

OTHER ADMIN. POLICY CHANGE NUMBER: 10

(Dollars in Thousands)

FY 2014-15		Printing	Mailing	TF	GF	FF
Mass Mailings		$0	$9,950	$9,950	$4,975	$4,975
Eligibility	Distribution	$0	$520	$520	$260	$260
	Routine	$2,400	$1,000	$3,400	$1,700	$1,700
	EITC Annual insert*	$400	$0	$400	$400	$0
	PARIS	$154	$46	$200	$100	$100
Incarceration Verification Program		$39	$12	$51	$26	$25
Benefits		$600	$1,000	$1,600	$800	$800
BCCTP (35% State-Only Eligs)		$5	$16	$21		
	*35% State-Only	$0	$0	$0	$7	$0
	65% 50/50 Split	$0	$0	$0	$7	$7
HIPAA NPP - M/C		$2,200	$2,000	$4,200	$2,100	$2,100
HIPAA NPP - BCCTP		$30	$10	$40	$20	$20
TOTAL (Rounded)		$5,828	$14,554	**$20,382**	**$10,395**	**$9,987**

(Dollars in Thousands)

FY 2015-16		Printing	Mailing	TF	GF	FF
Mass Mailings		$0	$10,000	$10,000	$5,000	$5,000
Eligibility	Distribution	$0	$520	$520	$260	$260
	Routine	$2,400	$1600	$4,000	$2,000	$2,000
	EITC Annual insert*	$400	$0	$400	$400	$0
	PARIS	$154	$46	$200	$100	$100
Incarceration Verification Program		$39	$12	$51	$26	$25
Benefits		$600	$1,000	$1,600	$800	$800
BCCTP (35% State-Only Eligs)		$5	$16	$21		
	*35% State-Only	$0	$0	$0	$7	$0
	65% 50/50 Split	$0	$0	$0	$7	$7
HIPAA NPP - M/C		$2,200	$2,000	$4,200	$2,100	$2,100
HIPAA NPP - FPACT		$0	$0	$0	$0	$0
HIPAA NPP - BCCTP		$30	$10	$40	$20	$20
TOTAL (Rounded)		$5,828	$15,204	**$21,032**	**$10,720**	**$10,312**

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

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	11
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1729

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$16,856,000	$16,093,000
STATE FUNDS	$600,000	$0
FEDERAL FUNDS	$16,256,000	$16,093,000

DESCRIPTION

Purpose:
This policy change estimates the county utilization review (UR) and quality assurance (QA) administrative costs for Specialty Mental Health Services (SMHS).

Authority:
Welfare & Institutions Code 14711

Interdependent Policy Changes:
Not Applicable

Background:
UR and QA activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel claims.

Reason for Change from Prior Estimate:
The percentage of payments made during each fiscal year has been updated based on historical paid claims data.

Methodology:
1. UR and QA expenditures are shared between federal funds (FF) and county funds (CF).

2. UR and QA costs are based on historical trends. UR and QA costs on an accrual basis are:

(Dollars in Thousands)

Fiscal Year	TF	FF	CF
FY 2012-13	$23,409	$15,789	$7,620
FY 2013-14	$23,917	$16,132	$7,785
FY 2014-15	$24,575	$16,575	$8,000
FY 2015-16	$25,302	$17,066	$8,236

SMHS COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 11

3. Based on historical claims received, assume 28% of the each fiscal year claims will be paid in the year the services occur. Assume 69% is paid in the following year and 3% is paid in the third year.

(Dollars in Thousands)

Fiscal Year	Accrual	FY 2014-15	FY 2015-16
FY 2012-13	$23,409	$702	$0
FY 2013-14	$23,917	$16,503	$718
FY 2014-15	$24,575	$6,881	$16,957
FY 2015-16	$25,302	$0	$7,085
Total		$24,086	$24,759

4. SPMP are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

5. Based on historical claims received, assume 60% are SPMP and the remaining 40% of the total claims are other personnel costs.

6. An additional $1,200,000 has been added to Other personnel costs in FY 2014-15 to prepare semi-annual reports for the Katie A. v. Bontá settlement agreement. The Katie A. v. Bontá settlement agreement costs are eligible for 50% FF and 50% General Fund (GF).

(Dollars in Thousands)

FY 2014-15

Personnel	TF	FF	CF	GF
SPMP	$14,452	$10,839	$3,613	$0
Other	$10,834	$5,417	$4,817	$600
Total	$25,286	**$16,256**	$8,430	**$600**

FY 2015-16

Personnel	TF	FF	CF
SPMP	$14,855	$11,141	$3,714
Other	$9,903	$4,952	$4,952
Total	$24,759	**$16,093**	$8,666

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

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER:	12
IMPLEMENTATION DATE:	7/2012
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1722

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$15,817,000	$16,867,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$15,817,000	$16,867,000

DESCRIPTION

Purpose:
This policy change budgets the federal financial participation (FFP) for claims submitted on behalf of specialty mental health plans (MHPs) for Medicaid administrative activities.

Authority:
Welfare & Institutions Code 14132.47
AB 2377 (Chapter 147, Statutes of 1994)

Interdependent Policy Changes:
Not Applicable

Background:
AB 2377 authorized the State to implement the Medi-Cal Administrative Claiming Process. The Specialty Mental Health Waiver program submits claims on behalf of MHPs to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the specialty mental health waiver program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of specialty mental health services.

Reason for Change from Prior Estimate:
The estimates are revised to account for the most recent claims data.

Methodology:
1. County mental health plans submit claims for reimbursement on a quarterly basis. Claims may be submitted up to six months after the close of a fiscal year (FY).

2. Based on claims from FY 2006-07 through FY 2012-13, the average annual increase in mental health (MH) Medi-Cal administrative activities (MAA) claims was 6.63%.

3. Assume claims will continue to increase by 6.63% each year for FY 2013-14, FY 2014-15, and FY 2015-16.

SMH MAA

OTHER ADMIN. POLICY CHANGE NUMBER: 12

4. For FY 2012-13, the Department received $24,433,000 in MH MAA claims on an accrual basis.

(Dollars in Thousands)

Fiscal Years	Expenditures	Growth	Increase
FY 2012-13	$24,433	6.63%	$1,620
FY 2013-14	$26,053	6.63%	$1,727
FY 2014-15	$27,780	6.63%	$1,842
FY 2015-16	$29,622	6.63%	$1,964

5. Based on historical claims received, assume 21.47% of fiscal year claims will be paid in the year the services occur. The remaining 78.53% is paid in the following year.

(Dollars in Thousands)

Fiscal Years	Accrual	FY 2014-15	FY 2015-16
FY 2013-14	$26,053	$20,459	$0
FY 2014-15	$27,780	$5,964	$21,816
FY 2015-16	$29,622	$0	$6,360
Total	$83,455	$26,423	$28,176

6. MH MAA total expenditures are shared between FFP and county funds. Skilled professional medical personnel are eligible for enhanced federal reimbursement of 75%. All other personnel are eligible for 50% federal reimbursement.

(Dollars in Thousands)

	FY 2014-15			FY 2015-16		
Fiscal Year	**TF**	**FFP**	**County**	**TF**	**FFP**	**County**
Medical	$10,421	**$7,816**	$2,605	$11,113	**$8,335**	$2,778
Other	$16,002	**$8,001**	$8,001	$17,063	**$8,532**	$8,531
Total	$26,423	**$15,817**	$10,606	$28,176	**$16,867**	$11,309

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

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER:	13
IMPLEMENTATION DATE:	7/2014
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1813

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$15,082,000	$17,742,000
STATE FUNDS	$1,617,000	$2,113,000
FEDERAL FUNDS	$13,465,000	$15,629,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs for counties who provide Drug Medi-Cal (DMC) services.

Authority:
State Plan Amendment #09-022

Interdependent Policy Changes:
Not Applicable

Background:
Counties may obtain federal reimbursement for certain costs associated with administering DMC services. Starting July 1, 2014, DMC requires counties to report and bill for their county administration expenses separate from direct treatment services expenses. This reporting is required on a quarterly basis and the counties will continue annual reporting of county administration expenses in the annual cost report.

Prior to July 1, 2014, counties certified DMC claims submitted for reimbursement for direct treatment services and county administration services combined. For approved claims, the Department drew down federal Medicaid reimbursement funds based on the total certified expense and paid counties the federal share of the total certified expense, based on the DMC reimbursement rate. Counties reported the county administrative expenses in the annual cost report.

Starting FY 2014-15, the following changes were made:

- DMC reimbursement rate-setting methodologies excluded county administration expenses.
- The Department reimburses counties for DMC county administration expenses through a new invoicing process.
- The Department will implement a new process allowing counties to claim and be paid for county administrative expenses on a quarterly basis.

Reason for Change from the Prior Estimate:
This policy change has been updated with expenditure projections.

Methodology:
1. Based on the FY 2011-12 annual cost reports, the county administration costs was $16,222,000

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 13

for Regular DMC services and $371,000 for Perinatal DMC services.

2. The Department assumes a 10% annual increase (from FY 2011-12 to FY 2012-13, FY 2012-13 to FY 2013-14, FY 2013-14 to FY 2014-15, and FY 2014-15 to FY 2015-16).

Regular DMC

Service	FY 2011-12 County Admin Cost	10% Increase from FY 2011-12 to FY 2012-13	10% Increase from FY 2012-13 to FY 2013-14	10% Increase from FY 2013-14 to FY 2014-15	10% Increase from FY 2014-15 to FY 2015-16
Narcotic Treatment Program	$7,781,000	$8,559,100	$9,415,010	$10,357,000	$11,393,000
Intensive Outpatient Treatment	$2,368,000	$2,605,000	$2,866,000	$3,153,000	$3,468,000
Outpatient Drug Free	$6,073,000	$6,680,000	$7,348,000	$8,083,000	$8,891,000
Total	$16,222,000	$17,844,100	$19,629,010	**$21,593,000**	**$23,752,000**

Perinatal DMC

Service	FY 2011-12 County Admin Cost	10% Increase from FY 2011-12 to FY 2012-13	10% Increase from FY 2012-13 to FY 2013-14	10% Increase from FY 2013-14 to FY 2014-15	10% Increase from FY 2014-15 to FY 2015-16
Narcotic Treatment Program	$25,000	$28,000	$31,000	$34,000	$37,000
Intensive Outpatient Treatment	$118,000	$130,000	$143,000	$157,000	$173,000
Residential Treatment	$152,000	$167,000	$184,000	$202,000	$222,000
Outpatient Drug Free (ODF)	$76,000	$84,000	$92,000	$101,000	$111,000
Total	$371,000	$409,000	$450,000	**$494,000**	**$543,000**
				Total FY 2014-15	**Total FY 2015-16**
				$22,087,000	**$24,295,000**

3. Aid codes for the Medicaid Children's Health Insurance Program (M-CHIP), for the Breast and Cervical Cancer Treatment (BCCTP) program, and for pregnancy-related services are eligible

DRUG MEDI-CAL COUNTY ADMINISTRATION

OTHER ADMIN. POLICY CHANGE NUMBER: 13

for Title XXI federal reimbursement of 65%. Minor consent costs are funded by the counties. All other Medi-Cal claims are eligible for 50% federal reimbursement.

	Estimated County Admin	County Funds	Title XIX	Title XXI	GF
Regular DMC	$21,593,000	$6,855,000	$13,025,000	$96,000	$1,617,000
Perinatal DMC	$494,000	$150,000	$168,000	$176,000	$0
Total FY 2014-15	$22,087,000	$7,005,000	**$13,193,000**	**$272,000**	**$1,617,000**

	Estimated County Admin	County Funds	Title XIX	Title XXI	GF
Regular DMC	$23,752,000	$6,409,000	$15,130,000	$100,000	$2,113,000
Perinatal DMC	$543,000	$144,000	$141,000	$258,000	$0
Total FY 2015-16	$24,295,000	$6,553,000	**$15,271,000**	**$358,000**	**$2,113,000**

Funding:
Title XIX 100% FF (4260-101-0890)
Title XXI 100% FF (4260-113-0890)
100% General Fund (4260-101-0001)
100% General Fund (4260-113-0001)

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER:	14
IMPLEMENTATION DATE:	7/2002
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	252

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$14,000,000	$12,476,000
STATE FUNDS	$3,710,000	$3,317,000
FEDERAL FUNDS	$10,290,000	$9,159,000

DESCRIPTION

Purpose:
The policy change estimates the contract costs associated with the Management Information System/Decision Support System (MIS/DSS).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The MIS/DSS houses a variety of Medicaid-related data and incorporates it into an integrated, business intelligence system. The system is used by the Department and other approved entities. The Department uses the system in various ways, including:

- The Medi-Cal Managed Care Division in its monitoring of Health Plan performance,
- The Third Party Liability and Recovery Division in its collection efforts, and
- The Audits and Investigations Division in its anti-fraud efforts.

Ongoing enhancement, operation and maintenance of the MIS/DSS are accomplished through a multi-year contract. The Department has awarded a new nine year contract for the ongoing maintenance and operation of the MIS/DSS to begin March 1, 2015.

Reason for Change from Prior Estimate:
Expenditures have been updated to reflect the newly awarded contract costs.

Methodology:
1. It is estimated that the contractor will be paid the following amounts in FY 2014-15 and FY 2015-16:

FY 2014-15:	**TF**	**GF**	**FF**
Fixed Costs (75% FF / 25% GF)	$9,848,000	$2,462,000	$7,386,000
Additional Fixed Costs (50% FF / 50% GF)	$840,000	$420,000	$420,000
Variable Costs (75% FF / 25% GF)	$3,312,000	$828,000	$2,484,000
Total	**$14,000,000**	**$3,710,000**	**$10,290,000**

MIS/DSS CONTRACT

OTHER ADMIN. POLICY CHANGE NUMBER: 14

FY 2015-16:	TF	GF	FF
Fixed Costs (75% FF / 25% GF)	$8,875,000	$2,219,000	$6,656,000
Additional Fixed Costs (50% FF / 50% GF)	$792,000	$396,000	$396,000
Variable Costs (75% FF / 25% GF)	$2,809,000	$702,000	$2,107,000
Total	**$12,476,000**	**$3,317,000**	**$9,159,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	15
IMPLEMENTATION DATE:	7/2009
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1381

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$9,980,000	$9,980,000
STATE FUNDS	$4,990,000	$4,990,000
FEDERAL FUNDS	$4,990,000	$4,990,000

DESCRIPTION

Purpose:
This policy change estimates the costs of litigation and actuarial consulting.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department continues to experience an increase in the number and complexity of litigation cases challenging legislation implementing changes to the Medi-Cal program. As a result, the Department of Justice costs and other litigation support costs have increased from previous years.

Several significant cases, which had previously been inactive awaiting a precedential decision by the United States Supreme Court, continue to be active. Also, ongoing litigation filed by managed care plans relating to capitation rates has resulted in significant time expended by actuarial staff in evaluating the cases and developing defense strategies.

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

Methodology:
1. Based on prior Department of Justice litigation costs and projected workload, costs are projected to be $7,880,000 for FY 2014-15, and $7,880,000 for FY 2015-16.

2. Based on prior actuary costs and the Department's projected workload, costs will be $2,100,000 in FY 2014-15 and $2,100,000 in FY 2015-16.

LITIGATION RELATED SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 15

	FY 2014-15		FY 2015-16	
	TF	GF	TF	GF
Litigation Representation	$ 7,880,000	$ 3,940,000	$ 7,880,000	$ 3,940,000
Consulting Actuaries	$ 2,100,000	$ 1,050,000	$ 2,100,000	$ 1,050,000
Total	**$ 9,980,000**	**$ 4,990,000**	**$ 9,980,000**	**$ 4,990,000**

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

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	16
IMPLEMENTATION DATE:	1/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1871

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$9,268,000	$21,626,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$9,268,000	$21,626,000

DESCRIPTION

Purpose:
This policy change estimates the Drug Medi-Cal (DMC) Utilization Review (UR) and Quality Assurance (QA) administrative costs.

Authority:
Welfare and Institutions Code, Section 14711

Interdependent Policy Changes:
Not Applicable

Background:
UR/QA activities safeguard against unnecessary and inappropriate medical care and expenses. Federal Funds (FF) reimbursement for these costs is available at 75% for skilled professional medical personnel (SPMP) and 50% for all other personnel.

Beginning July 1, 2014, counties may begin claiming FFP reimbursement for DMC UR/QA administrative activities. Counties will begin billing for DMC UR/QA activities on January 1, 2015. DMC expects to release an information notice describing the new DMC UR/QA reimbursement process by November 14, 2014.

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

Methodology:
1. UR and QA expenditures are shared between FF and county funds (CF).

2. Assume the DMC cost of performing UR/QA activities is the same as the mental health cost of performing the same activities based on the similarity of duties.

3. Assume the UR and QA reimbursements begin January 1, 2015.

DMC COUNTY UR & QA ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 16

4. The UR and QA estimated costs on an accrual basis are:

(Dollars in Thousands)

	TF	FF	CF
FY 2014-15	$19,011	$12,619	$6,392
FY 2015-16	$38,022	$25,237	12,785

5. Assume 75% of each fiscal year claims will be paid in the year that the services occur and 25% is paid in the following year. The UR and QA estimated costs on a cash basis are:

(Dollars in Thousands)

	Accrual	FY 2014-15	FY 2015-16
FY 2014-15	$19,011	$14,258	$4,753
FY 2015-16	$38,022	$0	$28,517
Total	$57,033	$14,258	$33,270

6. Assume 60% of the total claims are for SPMP costs and the remaining 40% are for other personnel costs.

(Dollars in Thousands)

FY 2014-15

Personnel	TF	FFP	CF
SPMP	$8,555	$6,416	$2,139
Other	$5,703	$2,852	$2,851
Total	$14,258	**$9,268**	$4,990

FY 2015-16

Personnel	TF	FFP	CF
SPMP	$19,962	$14,972	$4,990
Other	$13,308	$6,654	$6,654
Total	$33,270	**$21,626**	$11,644

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

CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER:	17
IMPLEMENTATION DATE:	5/2010
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1322

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$8,433,000	$4,450,000
STATE FUNDS	$1,634,600	$639,000
FEDERAL FUNDS	$6,798,400	$3,811,000

DESCRIPTION

Purpose:
This policy change estimates the transition cost related to replacement and transition of the California Medicaid Management Information System (CA-MMIS).

Authority:
Title XIX of the Federal Social Security Act 1903(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
CA-MMIS is the claims processing system used for Medi-Cal. The transition costs incurred for CA-MMIS Replacement activities include interfacing with other Departmental mission critical systems such as Medi-Cal Eligibility Data System, Enhanced Medi-Cal Budget Estimate Redesign, State Controller's Office, Management Information System and Decision Support System, California Healthcare Eligibility, Enhancement and Retention System and Paid Claims and Encounters Standardization applications that require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system, user acceptance and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Replacement phase. The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during the Replacement phase. Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS Replacement phase.

Reason for Change from Prior Estimate:
FY 2014-15 contract costs increased due to newly executed contracts that were not in place in the prior estimate.

Methodology:
1. Advanced planning documents for these activities provide the basis for these estimates.

CA-MMIS SYSTEM REPLACEMENT OTHER STATE TRANSITION

OTHER ADMIN. POLICY CHANGE NUMBER: 17

FY 2014-15:	TF	GF	FF
50% Title XXI / 50% GF	$38,000	$19,000	$19,000
75% Title XIX / 25% GF	$4,160,000	$1,040,000	$3,120,000
90% Title XIX / 10% GF	$4,066,000	$407,000	$3,659,000
100% GF	$169,000	$169,000	$0
Total	**$8,433,000**	**$1,635,000**	**$6,798,000**

FY 2015-16:	TF	GF	FF
50% Title XXI / 50% GF	$20,000	$10,000	$10,000
75% Title XIX / 25% GF	$706,000	$177,000	$529,000
90% Title XIX / 10% GF	$3,635,000	$364,000	$3,271,000
100% GF	$89,000	$89,000	$0
Total	**$4,450,000**	**$640,000**	**$3,810,000**

Funding:
50% Title XXI / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)
100% GF (4260-101-0001)

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	18
IMPLEMENTATION DATE:	7/2012
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1677

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$8,202,000	$6,268,000
STATE FUNDS	$3,112,000	$3,134,000
FEDERAL FUNDS	$5,090,000	$3,134,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs for the Coordinated Care Initiative (CCI).

Authority:
SB 1008 (Chapter 33, Statutes of 2012)
SB 1036 (Chapter 45, Statutes of 2012)
SB 94 (Chapter 37, Statutes of 2013)

Interdependent Policy Changes:
Not Applicable

Background:
In coordination with Federal and State Government, the CCI will provide benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles). CCI aims to improve service delivery for people with dual eligibility and Medi-Cal only beneficiaries who rely on long-term services and supports (LTSS) to maintain residence in their communities. LTSS includes both home and community-based services and institutional long-term care services. Services will be provided through the managed care delivery system for all Medi-Cal beneficiaries who rely on such services. The Department will be hiring contractors to do the following:

- Stakeholder and advocate outreach,
- Rate setting,
- Medicare and Medi-Cal data analysis,
- Quality assurance and monitoring by an External Quality Review Organization (EQRO),
- Ombudsman – Infrastructure Development,
- IT Project Management, and
- Data Outcomes and Evaluation Development.

Reason for Change from Prior Estimate:
In FY 2014-15, the Centers for Medicare and Medicaid Services (CMS) increased the allotted grant funding for California. Additionally, the ACA FMAP was updated. The Department entered year two of the grant, which decreases the ACA FMAP from 100% FF to 75% FF and 25% GF.

Methodology:
1. The CCI development, implementation and operation costs began July 2012 and will continue through FY 2015-16.

CCI-ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 18

2. The Affordability Care Act (ACA) authorizes funding for the CCI and provides 75% federal financial participation (FFP) in FY 2014-15 to carry out the deliverables between the Department and CMS.

2014-15 Costs	TF	GF	FF	ACA FF
Stakeholder and Advocate Outreach	$4,248,000	$2,124,000	$2,124,000	$0
Rate Setting	$800,000	$200,000	$0	$600,000
IT Costs	$9,000	$2,250	$0	$6,750
Encounter Data Quality & Perform. Measures	$1,158,000	$289,500	$0	$868,500
EQRO Monitoring	$1,987,000	$496,750	$0	$1,490,250
Total	**$8,202,000**	**$3,112,500**	**$2,124,000**	**$2,965,500**

2015-16 Costs	TF	GF	FF	ACA FF
Stakeholder and Advocate Outreach	$4,248,000	$2,124,000	$2,124,000	$0
Rate Setting	$1,010,000	$505,000	$505,000	$0
Encounter Data Quality & Perform. Measures	$1,010,000	$505,000	$505,000	$0
Total	**$6,268,000**	**$3,134,000**	**$3,134,000**	**$0**

Funding:
50% Title XIX / 50% GF (4260-101-0890/0001)
ACA 75% Title XIX / 25% GF (4260-101-0890/0001)

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER:	19
IMPLEMENTATION DATE:	2/2008
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1551

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$7,004,000	$5,858,000
STATE FUNDS	$1,751,000	$1,464,500
FEDERAL FUNDS	$5,253,000	$4,393,500

DESCRIPTION

Purpose:
This policy change estimates the cost of the health insurance (HI) contracts to identify recipients with third party health insurance coverage and workers' compensation (WC) insurance. The policy change also includes online database contracts to access online activity and data matches in support of recovery.

Authority:
Contracts:

Department of Industrial Relations - Electronic Adjudication Management System (EAMS)	09-86353 A01
Department of Industrial Relations - (EAMS)	14-90130
Department of Industrial Relations - Worker's Compensation Information System (WCIS)	11-88136
Department of Industrial Relations - (WCIS)	14-90133
Department of Social Services	10-87009 A01
Health Management Systems Inc. (HI)	08-85000 A02
Health Management Systems Inc. (HI)	13-90283
Health Management Systems Inc. (WC)	03-75807 A03
Health Management Systems Inc. (WC)	03-75060 A03
Health Management Systems Inc. (WC)	07-65000 A06
Health Management Systems Inc. (WC)	07-65001 A06
Health Management Systems Inc. (WC)	12-89100
Health Management Systems Inc. (WC)	12-89101
Lexis-Nexis	11-88003 A01
Lexis-Nexis	14-90131
Boehm & Associates	97-10689 A02
Boehm & Associates	97-10690 A02
Department of Public Health	10-87020 A01
Department of Public Health	11-88117
Department of Public Health	13-90373
Department of Public Health	14-90132

Interdependent Policy Changes:
Not Applicable

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 19

Background:
Since Medi-Cal is the payer of last resort, other health plans must first be billed before the Medi-Cal program. The contracts provide:

1. Data matches between the Department's Medi-Cal Recipient Eligibility file and the contractor's policy holder/subscriber file;

2. Identification and recovery of Medi-Cal expenditures in WC actions;

3. Identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer;

4. Online access to research database services for public records of Medi-Cal recipients; and

5. Cost avoidance activities.

When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries. Recoveries due to WC vendor activities are budgeted in the Base Recoveries policy change. Recoveries due to health insurance vendor activities are incorporated into the base estimate.

The current health insurance contract was awarded to Health Management Systems with an effective date of December 1, 2013 and ends on November 30, 2018.

The WC contract was awarded to Health Management Systems with an effective date of May 1, 2013 and ends on April 30, 2017.

Reason for Change from Prior Estimate:
WC Contract costs increased as a result of payments made for outstanding invoices and an increase in anticipated recoveries in FY 2014-15; HI Contract costs have increased slightly to account for additional year end recoveries that were received, and; the Online Database Contract costs increased due to the addition of new contracts.

Methodology:
1. The amounts paid to the contractors are based upon recoveries. The payments shown below include recent recovery activity.

FY 2014-15	**TF**	**GF**	**FF**
Health Insurance	$5,546,000	$1,386,500	$4,159,500
WC	$1,350,000	$337,500	$1,012,500
Online Database Contracts	$108,000	$27,000	$81,000
Total	**$7,004,000**	**$1,751,000**	**$5,253,000**

FY 2015-16	**TF**	**GF**	**FF**
Health Insurance	$5,100,000	$1,275,000	$3,825,000
WC	$675,000	$168,750	$506,250
Online Database Contracts	$83,000	$20,750	$62,250
Total	**$5,858,000**	**$1,464,500**	**$4,393,500**

MEDI-CAL RECOVERY CONTRACTS

OTHER ADMIN. POLICY CHANGE NUMBER: 19

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER:	20
IMPLEMENTATION DATE:	2/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1731

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$6,696,000	$2,779,000
STATE FUNDS	$669,600	$660,900
FEDERAL FUNDS	$6,026,400	$2,118,100

DESCRIPTION

Purpose:
This policy change estimates the cost to hire contractors to conduct a feasibility study, develop an Advance Planning Document (APD), and participate in the project planning efforts.

Authority:
Title 42, Code of Federal Regulations, Sections 95.611 and 433.110

Interdependent Policy Changes:
Not Applicable

Background:
The Department is seeking to transition the Medi-Cal Eligibility Data System (MEDS) from a stand-alone legacy system to a modernized, integrated solution that addresses the requirements of the federal Affordable Care Act, and increases the Department's alignment with the federal Medicaid Information Technology Architecture.

The Department submitted the Planning APD (PAPD) for the planning phase of the MEDS Modernization Project in March 2014. Due to delays in CMS approval of the PAPD, project planning phase activities are anticipated to continue through November 2016. Beginning in FY 2014-15, additional contractors will be hired to provide project planning, support, Business Rules Extraction (BRE), enterprise architecture, and other technical consulting services.

Reason for Change from Prior Estimate:
The scope of project planning activities has been expanded, and costs shifted from FY 2013-14 to FY 2014-15 due to the delay in obtaining PAPD approval from CMS.

Methodology:
1. The FY 2014-15 and FY 2015-16 costs are based on estimated costs for payments to the project planning, support, enterprise architecture, technical consulting, and BRE contractors contained in the project's PAPD. Payments are expected to begin in November 2014.

2. The FY 2014-15 costs are at 90/10 FFP.

MEDS MODERNIZATION

OTHER ADMIN. POLICY CHANGE NUMBER: 20

FY 2014-15:	TF	GF	FF
Project Planning	$676,000	$68,000	$608,000
Technical Consulting Services	$900,000	$90,000	$810,000
Project Support	$360,000	$36,000	$324,000
Enterprise Architects	$540,000	$54,000	$486,000
Other Contractor Costs	$843,000	$84,000	$759,000
Business Rules Extraction	$3,377,000	$338,000	$3,039,000
Total	**$6,696,000**	**$670,000**	**$6,026,000**

FY 2015-16:	TF	GF	FF
Project Planning			
(90% FF / 10% GF)	$507,000	$51,000	$456,000
(50% FF / 50% GF)	$507,000	$253,000	$254,000
Technical Consulting Services (90% FF / 10% GF)	$450,000	$45,000	$405,000
Project Support			
(90% FF / 10% GF)	$270,000	$27,000	$243,000
(50% FF / 50% GF)	$270,000	$135,000	$135,000
Enterprise Architects (90% FF / 10% GF)	$270,000	$27,000	$243,000
Other Contractor Costs			
(90% FF / 10% GF)	$77,000	$8,000	$69,000
(50% FF / 50% GF)	$32,000	$16,000	$16,000
Business Rules Extraction (75% FF / 25% GF)	$396,000	$99,000	$297,000
Total	**$2,779,000**	**$661,000**	**$2,118,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER:	21
IMPLEMENTATION DATE:	7/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1720

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$6,583,000	$8,150,000
STATE FUNDS	$1,645,750	$2,037,500
FEDERAL FUNDS	$4,937,250	$6,112,500

DESCRIPTION

Purpose:
This policy change estimates the contract cost for the Preadmission Screening and Resident Review (PASRR) Level II evaluations. The policy change also estimates the costs of designing, testing, and implementing a web based automation system to bring PASRR into compliance with federal mandates.

Authority:
Title 42, Code of Federal Regulations 483.100-483.136, 483.200-483.206

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations mandate that the Department have an independent contractor complete all Level II PASRR Evaluations. The current contractor completes Level II evaluations for the federally mandated PASRR program. A Level II evaluation consists of a face to face mental status examination and psychosocial assessment for individuals identified with mental illness upon admission to a nursing facility. The findings of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. The contractor's licensed clinical evaluators conduct the Level II evaluations on behalf of the State and enter their findings into the PASRR database.

The contract for the Level II evaluations ends December 2014. The Department is in the process of issuing a Request for Proposal for a new contract effective January 2015 through FY 2017-18 (with two one-year options to renew).

PASRR received funding to design, test, and implement a web based automated system to bring the preadmission Level I Screening, Level II evaluation, and Level II determination processes into compliance with federally mandated regulations for PASRR. The IT project will replace an inefficient mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The Department will save money by not contracting with a consultant to support the current mainframe and by hosting the new application in-house. The new IT system will:

- Be in compliance with federal mandates related to PASRR,
- Allow multiple agencies to submit electronic screening documents,
- Significantly reduce processing time for submissions,
- Eliminate paper submissions,

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 21

- Reduce the time a contractor takes to return completed evaluations, and
- Increase efficiencies for PASRR clinicians by reducing processing time for determinations.

Due to additional IT system enhancements identified, the Department is in the process of issuing a Request for Offer for these enhancements in July 2014. These enhancements include:

- Developing an off-line tablet application that the Level II evaluators can use in the nursing facilities (NFs) to expedite the evaluation process.
- Developing a Reconsideration Letter feature for the NFs to request a reconsideration if they disagree with the Department's determination and care plan for the patient.
- Providing the Department with the ability to activate, deactivate, and reset user accounts directly from the new application instead of using the Web Admin tool.
- Developing a Bed-Hold feature so the NFs can inform the Department that the patient has been temporarily sent back to the hospital but they need to hold the bed for at least 10 days.
- Developing the new system to look up ICD 9/10 codes for the Program Clinicians and the Level II evaluators.

Reason for Change from Prior Estimate:
Due to a delay in the project, costs will carry over to FY 2014-15 and there will be additional costs incurred with the new IT contract. In addition, the current service contract for Level II Evaluations was extended to December 31, 2014 with the new contractor scheduled to begin in January 2015.

Methodology:

1. There was a 60% increase in the number of completed Level II evaluations returned by the Contractor in FY 2012-13. As of June 2014, there is an additional increase of 15% in the number of completed Level II evaluations returned by the contractor. It is projected that the volume of Level II evaluations will rise significantly in the future. The IT project will allow preadmission screening to be conducted as mandated and may significantly increase the number of Level II evaluations needed.

2. Assume the new Level II evaluations contractor will be hired in January 2015, and payments will begin in February 2015.

3. PASRR contract costs are eligible for enhanced federal reimbursement of 75% FF and 25% GF.

4. PASRR received $1,000,000 for the IT project with 75% FF and 25% GF.

5. Assume the IT project requires maintenance and operations (M&O) costs of a $150,000 annually. For FY 2014-15, the M&O costs will begin in January 2015. These costs are funded with 75% FF and 25% GF.

FY 2014-15	TF	GF	FF
Evaluations	$5,630,000	$1,408,000	$4,222,000
IT Project	$878,000	$220,000	$658,000
Ongoing M&O Costs	$75,000	$19,000	$56,000
	$6,583,000	**$1,647,000**	**$4,936,000**

PASRR

OTHER ADMIN. POLICY CHANGE NUMBER: 21

FY 2015-16	TF	GF	FF
Evaluations	$8,000,000	$2,000,000	$6,000,000
Ongoing M&O Costs	$150,000	$38,000	$112,000
	$8,150,000	**$2,038,000**	**$6,112,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER:	22
IMPLEMENTATION DATE:	7/2009
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1441

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$5,558,000	$5,836,000
STATE FUNDS	$1,850,500	$1,943,250
FEDERAL FUNDS	$3,707,500	$3,892,750

DESCRIPTION

Purpose:
This policy change estimates the maintenance expenditures and reimbursements for the Medi-Cal Eligibility Data System (MEDS), the statewide database containing eligibility information for public assistance programs administered by the Department and other departments.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status. Funding is required for the following:

- MEDS Master Client Index maintenance,
- Data matches from various federal and state agencies,
- Supplemental Security Income termination process support,
- Medi-Cal application alerts,
- Medicare Modernization Act Part D buy-in process improvements,
- Eligibility renewal process, and
- Reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities.

Costs are offset by reimbursements made from other departments.

In addition, maintenance funding is required for the Business Objects software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.

MEDS supports the Advance Premium Tax Credit and Cost Share Reduction programs with Covered California and respective interfaces with CalHEERS, and County consortia. The MEDS Statewide Client Index generates unique Client Index Numbers for all populations.

Reason for Change from Prior Estimate:
Costs were adjusted to accommodate increases in the State Data Center, the Office of Technology Services (OTech). OTech houses the mainframe which is the vehicle used to access MEDS and MEDS' respective data used to support of the Medi-Cal eligibility program.

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS)

OTHER ADMIN. POLICY CHANGE NUMBER: 22

Methodology:

1. The following are the projected costs for FY 2014-15 and FY 2015-16.

FY 2014-15:	**TF**	**GF**	**FF**
(50% FF / 50% GF)	$674,000	$337,000	$337,000
(75% FF / 25% GF)	$4,494,000	$1,124,000	$3,370,000
(100% Reimbursement)	$390,000	$390,000	$0
Total	**$5,558,000**	**$1,851,000**	**$3,707,000**

FY 2015-16:	**TF**	**GF**	**FF**
(50% FF / 50% GF)	$707,000	$353,000	$354,000
(75% FF / 25% GF)	$4,719,000	$1,180,000	$3,539,000
(100% Reimbursement)	$410,000	$410,000	$0
Total	**$5,836,000**	**$1,943,000**	**$3,893,000**

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
100% Reimbursement (4260-601-0995)

CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER:	23
IMPLEMENTATION DATE:	10/2007
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1278

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$5,252,000	$8,113,000
STATE FUNDS	$629,300	$971,900
FEDERAL FUNDS	$4,622,700	$7,141,100

DESCRIPTION

Purpose:
This policy change estimates the cost of contractors who assist with the oversight of the replacement of the California Medicaid Management Information System (CA-MMIS).

Authority:
Title XIX of the Federal Social Security Act 1903(a)(3)

Interdependent Policy Changes:
Not Applicable

Background:
CA-MMIS is the claims processing system used for Medi-Cal. Given the business critical nature of CA-MMIS, a detailed assessment was completed and the recommendation was to immediately modernize CA-MMIS. The Department contracts with various vendors to assist with highly specialized Fiscal Intermediary oversight activities, documentation of business rules, technical architecture, federal certification management, project management, transition management, and independent verification and validation services during transition and replacement of the CA-MMIS system.

Reason for Change from Prior Estimate:
For FY 2014-15, costs decreased due to the cancellation of contracts that were planned or in the process of being procured.

Methodology:
1. The estimated costs are based upon the contract provisions.

FY 2014-15:	TF	GF	FF
50% Title XXI / 50% GF	$24,000	$12,000	$12,000
90% Title XIX / 10% GF	$5,123,000	$512,000	$4,611,000
100% GF	$105,000	$105,000	$0
Total	**$5,252,000**	**$629,000**	**$4,623,000**

FY 2015-16:	TF	GF	FF
50% Title XXI / 50% GF	$37,000	$18,000	$19,000
90% Title XIX / 10% GF	$7,914,000	$791,000	$7,123,000
100% GF	$162,000	$162,000	$0
Total	**$8,113,000**	**$971,000**	**$7,142,000**

CA-MMIS SYSTEM AND REPLACEMENT OVERSIGHT

OTHER ADMIN. POLICY CHANGE NUMBER: 23

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

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER:	24
IMPLEMENTATION DATE:	10/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1318

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$5,144,000	$4,865,000
STATE FUNDS	$1,286,000	$1,216,250
FEDERAL FUNDS	$3,858,000	$3,648,750

DESCRIPTION

Purpose:
This policy change estimates the contract costs to make improvements, maintain, and operate the existing Health Insurance Portability and Accountability Act (HIPAA) Capitation Payment Reporting system (CAPMAN). The HIPAA imposes new transaction requirements (5010).

Authority:
45 CFR Part 162

Interdependent Policy Changes:
Not Applicable

Background:
The CAPMAN system was implemented by the Department in July 2011. The HIPAA compliant transaction automated and improved the capitation calculation process. CAPMAN allows detailed reporting at the beneficiary level while increasing the effectiveness of monthly reconciliations and supports research efforts to perform recoveries.

Due to the Affordable Care Act (ACA) and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to accommodate the influx of new beneficiaries. Modifications are being made to further enhance the system to incorporate a paperless accounting interface and accommodate the Coordinated Care Initiative (CCI) Duals Demonstration project. The system will have to be maintained on an ongoing basis, as new functionality is required. A two-year contract was executed in July 2013, and a one-year extension was exercised in April 2014 to address these issues. The contract has an end date of April 30, 2016.

Reason for Change from Prior Estimate:
Costs increased due to added staff required to continue updates on the CAPMAN system and incorporate CCI Duals mandated changes. Managed care caseload increased due to ACA, CCI Duals, and managed care expansion. CAPMAN supports managed care plans. An amendment has already been executed to increase funds for necessary staffing.

Methodology:
1. The contract costs will be $12,969,000 due to a contract amendment. Payments started at the beginning of August 2013.

2. The remaining balance of $10,009,000 will be paid out over the life of the contract.

HIPAA CAPITATION PAYMENT REPORTING SYSTEM

OTHER ADMIN. POLICY CHANGE NUMBER: 24

3. Contract costs:

	TF	GF	FF
FY 2014-15:	**$5,144,000**	**$1,286,000**	**$3,858,000**
FY 2015-16:	**$4,865,000**	**$1,216,000**	**$3,649,000**

Funding:
75% HIPAA FFP / 25% HIPPA Fund (4260-117-0001/0890)

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER:	25
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1824

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$4,190,000	$4,190,000
STATE FUNDS	$2,095,000	$2,095,000
FEDERAL FUNDS	$2,095,000	$2,095,000

DESCRIPTION

Purpose:
This policy change estimates the Newborn Hearing Screening Program's (NHSP) contract service costs.

Authority:
AB 2780 (Chapter 310, Statutes of 1998)
Health & Safety Code Section 123975 and Sections 124115 - 124120.5

Interdependent Policy Changes:
Not Applicable

Background:
The NHSP contracts with both the Hearing Coordination Centers (HCC) and the Data Management Service (DMS). The HCCs provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who needs follow-up to assure they receive the needed services and referrals.

The DMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The DMS provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.

The DMS and HCC contract breakdowns are as follows:

- There are four contracts that are active and extended to ensure ample time for Request for Proposal (RFP) and transition processes.
  - DMS contract #13-90151 A03 expires on December 31, 2014.
  - HCC contract #10-87040 A02, Loma Linda, expires on June 30, 2015.
  - HCC contract #10-87041 A02, Miller Children's Hospital, expires on June 30, 2015.
  - HCC contract #13-90151 A01, Natus Medical Incorporated, expires on September 30, 2015.
- There are RFP's, which have already been advertised, to renew the four contracts.
  - A statewide DMS RFP will be awarded September 15, 2014, and start October 1, 2014.
  - A statewide HCC RFP will be awarded November 12, 2014, and start December 1, 2014.
  - The new DMS contract will be effective for two years.
  - The new HCC contracts will be effective for five years.

NEWBORN HEARING SCREENING PROGRAM

OTHER ADMIN. POLICY CHANGE NUMBER: 25

- The new contract dates overlap the existing contracts to ensure proper transition of services.
  - The existing contracts will be cancelled once the new competitively bid contracts are awarded and implemented.

Reason for Change from Prior Estimate:
The net change for FY 2014-15 is due to one HCC amendment increasing and the emergency Natus HCC contract dropping off once the new competitively bid HCC contract is awarded.

Methodology:
1. Currently, the HCC's contract totals $3,690,000 and the DMS contract totals $500,000.

HCC contract	$3,690,000
DMS contract	$500,000
Total for FY 2014-15	**$4,190,000**
Total for FY 2015-16	**$4,190,000**

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

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER:	26
IMPLEMENTATION DATE:	7/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1732

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$3,000,000	$2,325,000
STATE FUNDS	$1,500,000	$1,162,500
FEDERAL FUNDS	$1,500,000	$1,162,500

DESCRIPTION

Purpose:
This policy change estimates the infrastructure and contractor's costs to perform the ongoing maintenance and operations support for the Short-Doyle/Medi-Cal (SDMC) system.

Authority:
Contract OHC-11-077

Interdependent Policy Changes:
Not Applicable

Background:
The SDMC system adjudicates Medi-Cal claims for Specialty Mental Health and Substance Use Disorder Services. The previous one-year maintenance and operations contract began June 30, 2013. The Department signed a two-year contract beginning July 1, 2014, with two one-year optional extensions. Due to the Affordable Care Act, Medi-Cal is expecting an increase in the volume of claims which has created a need for system upgrades, including application servers, reporting servers, middleware, database, and storage.

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

Methodology:

1. The estimated contractor cost for the new four-year contract is $8,000,000.
2. The new contractor was hired in July 2014, and payments will begin September 2014.
3. The estimated one-time infrastructure cost is $1,000,000 in FY 2014-15.
4. FY 2015-16 projections include the cost of ongoing maintenance and operation (M&O) for the accounting system that processes Mental Health claims payments for Short-Doyle.

FY 2014-15:	TF	GF	FF
Contractor cost	$2,000,000	$1,000,000	$1,000,000
Infrastructure cost	$1,000,000	$500,000	$500,000
Total	**$3,000,000**	**$1,500,000**	**$1,500,000**

SDMC SYSTEM M&O SUPPORT

OTHER ADMIN. POLICY CHANGE NUMBER: 26

FY 2015-16:	TF	GF	FF
Contractor cost	$2,000,000	$1,000,000	$1,000,000
M&O	$325,000	$162,000	$163,000
Total	**$2,325,000**	**$1,162,000**	**$1,163,000**

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

FAMILY PACT EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER:	27
IMPLEMENTATION DATE:	7/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1674

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$2,861,000	$2,861,000
STATE FUNDS	$1,430,500	$1,430,500
FEDERAL FUNDS	$1,430,500	$1,430,500

DESCRIPTION

Purpose:
This policy change estimates the costs for data and evaluation of reproductive health services under the Family Planning, Access, Care, and Treatment (Family PACT) and Medi-Cal programs.

Authority:
AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The University of California, San Francisco (UCSF) is conducting an evaluation of reproductive health services for the Family PACT and Medi-Cal programs. UCSF will evaluate the program's effectiveness, including the analysis of:

- Access by target populations,
- Changes in the provider base for target geographical areas,
- Provider compliance,
- Claims analysis, and
- Cost-effectiveness of services.

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

Methodology:
1. The data and evaluation costs for the Family PACT program are estimated in the table below:

	TF	GF	FFP
FY 2014-15	**$2,861,000**	**$1,431,000**	**$1,431,000**
FY 2015-16	**$2,861,000**	**$1,431,000**	**$1,431,000**

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

BUSINESS RULES EXTRACTION

OTHER ADMIN. POLICY CHANGE NUMBER:	28
IMPLEMENTATION DATE:	10/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1814

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$2,475,000	$835,000
STATE FUNDS	$247,500	$83,500
FEDERAL FUNDS	$2,227,500	$751,500

DESCRIPTION

Purpose:
This policy change estimates the cost of procuring a Business Rules Extraction (BRE) suite of tools and services, through the General Services Software License Program, for use in the creation and maintenance of a modernized automated comprehensive procurement library.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department included the BRE enhancement in the 2011 request for proposal for the California Dental Medicaid Management Information System (CD-MMIS). The contract was subsequently awarded, but it was not approved by CMS. The Department plans to procure a new dental MMIS contract that meets CMS's requirements.

In order to provide an equal advantage to all participating bidders, the Department plans to purchase a BRE suite of tools and services for use in the creation and maintenance of a modernized automated comprehensive procurement library. Bidders will gain a better understanding of the functionality and complexity of the legacy system CD-MMIS enabling them to complete an informed, more competitive bid.

This modernized procurement library will provide the following:

- Full disclosure of graphic and logical views of the applications/programs.
- Update business rules periodically, allowing viewing of the latest versions of process diagrams, source code flow charts, and source code details.
- Ability to electronically store documentation.
- Utilize extracted business rules to support future system enhancements, replacement, or the migration to one enterprise-wide system.

Reason for Change from Prior Estimate:
General Fund (GF) is now at 10% of the total cost rather than 50%.

Methodology:
1. The BRE was initially its own project funded at 50/50 federal funds (FF), but is now included in the CD-MMIS re-procurement Advance Planning Document and therefore, qualifies for 90/10 FF.

BUSINESS RULES EXTRACTION

OTHER ADMIN. POLICY CHANGE NUMBER: 28

2. Assume the BRE suite of tools and services will be procured in August 2014 and the services will be completed by August 2015.

3. Total estimated costs are $3.31 million.

4. In FY 2014-15, $2.475 million is expected to be paid. The remaining will be paid in FY 2015-16.

5. Payments will be payable in installments over a 12 month period, beginning with the Department approved start date of this project. The first payment is expected to be made in October 2014.

6. Premier Support invoices from the Software License Program Reseller will be payable on a monthly basis, based on actual hours worked.

	TF	GF	FF
FY 2014-15	**$ 2,475,000**	**$ 248,000**	**$ 2,227,000**

	TF	GF	FF
FY 2015-16	**$ 835,000**	**$ 84,000**	**$ 751,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)

PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER:	29
IMPLEMENTATION DATE:	2/2012
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1635

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$2,326,000	$1,375,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,326,000	$1,375,000

DESCRIPTION

Purpose:
This policy change budgets the federal funds awarded to the Department by the Centers of Medicare and Medicaid Services (CMS) for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project.

Authority:
Affordable Care Act (ACA), Section 4108

Interdependent Policy Changes:
Not Applicable

Background:
Section 4108 of the ACA authorized the five-year MIPCD grant project. California's MIPCD proposal created the Medi-Cal Incentives to Quit Smoking Project to use outreach and incentives to encourage access to smoking cessation services.

The Department contracted with the University of California San Francisco (UCSF) to implement, administer and evaluate the MIPCD program. The UCSF- California Medicaid Research Institute provides administrative support, coordination with key University of California (UC) partners, and contracts directly with the University of California San Diego (UCSD) to operate the California Smokers Helpline. The contract sunsets on September 12, 2016.

The California Smokers Helpline offers various incentives such as free counseling and nicotine replacement therapy to Medi-Cal beneficiaries. The MIPCD project also provides outreach services to Medi-Cal beneficiaries and Medi-Cal providers via the California Diabetes Program, which is administered by the Department of Public Health and UCSF.

Reason for Change from Prior Estimate:
The changes are due to:
- Unspent funds from Project Year 2013-14 will carry over to Project Year 2014-15.
- Remaining grant funds budgeted for Project Year 2015-16.

Methodology:
1. The Department was awarded the MIPCD grant on September 13, 2011 by CMS. A contract with UCSF was secured on January 27, 2012.

2. Projected costs are based on proposed contract amounts with UCSF for administration, implementation and evaluations associated with the MIPCD grant project.

PREVENTION OF CHRONIC DISEASE GRANT PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 29

3. On June 27, 2014, the Department submitted to CMS :
   - A $296,620 carryover request of unspent funds from Project Year 2013-14 (September 13, 2013 – September 12, 2014)
   - A $2,705,199 continuation request for Project Year 2014-15 (September 13, 2014 – September 12, 2015).

4. A $931,912 continuation request for Project Year 2015-16 (September 13, 2015 – September 12, 2016) is expected to be submitted to CMS by June 30, 2015.

Cash Basis		
FY 2014-15	**TF**	**FF**
Project Year 2013-14	$297,000	$297,000
Project Year 2014-15	$2,029,000	$2,029,000
	$2,326,000	**$2,326,000**
FY 2015-16		
Project Year 2014-15	$676,000	$676,000
Project Year 2015-16	$699,000	$699,000
	$1,375,000	**$1,375,000**

Funding:
MIPCD Federal Grant (4260-107-0890)

SSA COSTS FOR HEALTH COVERAGE INFO.

OTHER ADMIN. POLICY CHANGE NUMBER:	30
IMPLEMENTATION DATE:	1/1989
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	237

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$2,207,000	$2,207,000
STATE FUNDS	$1,103,500	$1,103,500
FEDERAL FUNDS	$1,103,500	$1,103,500

DESCRIPTION

Purpose:
This policy change estimates the cost of obtaining Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient information from the Social Security Administration (SSA).

Authority:
Social Security Act 1634(a)

Interdependent Policy Changes:
Not Applicable

Background:
The Department uses SSI/SSP information from the SSA to defer medical costs to other payers. The SSA administers the SSI/SSP programs. The SSI program is a federally funded program which provides income support for persons aged 65 or older and qualified blind or disabled individuals. The SSP is a state program which augments SSI. The Department receives SSI/SSP information about health coverage and assignment of rights to medical coverage from SSA. The SSA bills the Department quarterly for this activity.

Reason for Change from Prior Estimate:
FY 2014-15 projections have been updated based on actual invoices received to date.

Methodology:
1. The following projections are based upon recent actual billings from SSA.

(Dollars in Thousands)	TF	GF	FF
FY 2014-15	**$2,207**	**$1,104**	**$1,104**
FY 2015-16	**$2,207**	**$1,104**	**$1,104**

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

FAMILY PACT PROGRAM ADMIN.

OTHER ADMIN. POLICY CHANGE NUMBER:	31
IMPLEMENTATION DATE:	7/2012
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1675

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$1,207,000	$1,207,000
STATE FUNDS	$603,500	$603,500
FEDERAL FUNDS	$603,500	$603,500

DESCRIPTION

Purpose:
This policy change estimates the cost for provider recruitment, education, and support for the Family Planning, Access, Care, and Treatment (Family PACT) program.

Authority:
AB 1464 (Chapter 21, Statutes of 2012)

Interdependent Policy Changes:
Not Applicable

Background:
The Family PACT program has two main objectives. One is to increase access to services for low-income women and men, including adolescents. The other is to increase the number of providers who serve these clients. Education and support services are provided to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to:

- Public education, awareness, and direct client outreach,
- Provider enrollment, recruitment, and training,
- Training and technical assistance for medical and non-medical staff,
- Education and counseling services,
- Preventive clinical services,
- Sexually transmitted infection/HIV training and technical assistance services, and
- Toll-free referral number.

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

Methodology:
1. The administrative costs for the Family PACT program are estimated in the table below:

	TF	GF	FF
FY 2014-15	**$1,207,000**	**$603,500**	**$603,500**
FY 2015-16	**$1,207,000**	**$603,500**	**$603,500**

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

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER:	32
IMPLEMENTATION DATE:	9/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1768

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$1,108,000	$616,000
STATE FUNDS	$250,800	$125,800
FEDERAL FUNDS	$857,200	$490,200

DESCRIPTION

Purpose:
This policy change estimates the cost for 1) a contractor, 2) design, development and implementation (DD&I), and 3) ongoing maintenance and operations (M&O) of the Extract, Transform and Load (ETL) data solution.

Authority:
Required by the Centers for Medicare and Medicaid Services (CMS) to implement the Affordable Care Act (ACA)

Interdependent Policy Changes:
Not Applicable

Background:
CMS requests data in a standardized format from the states, which allows streamlining the review of system projects related to the ACA. The Department plans to implement an enterprise-wide ETL data solution to modernize and streamline the data transmission processes from the Department to the CMS's Transformed Statistical Information System. The project provides modern capabilities to improve business processes; by collecting comprehensive data regarding cost, quantity and quality of health care provided for Medi-Cal beneficiaries.

The Department procured a contractor to provide technical support for DD&I and M&O of the ETL data solution.

Reason for Change from Prior Estimate:
The contract is being extended again due to additional requirement changes from CMS.

Methodology:
1. The contractor began DD&I work in August 2013, and payments started in September 2013.
2. The DD&I contract duration was extended through December 2014 to meet the original requirement changes.
3. M&O costs began in September 2013.
4. The current M&O contract was extended through September 2014 to meet the original requirement changes.

ETL DATA SOLUTION

OTHER ADMIN. POLICY CHANGE NUMBER: 32

5. The Department is in the process of developing an Advance Planning Document Update to extend the contract to meet the additional CMS requirements. The anticipated completion date of the project is December 31, 2015.

FY 2014-15:	**TF**	**GF**	**FF**
DD&I (90% FF / 10% GF)	$188,000	$19,000	$169,000
M&O (75% FF / 25% GF)	$151,000	$38,000	$113,000
Software (75% FF / 25% GF)	$761,000	$190,000	$571,000
Hardware (50% FF / 50% GF)	$8,000	$4,000	$4,000
Total FY 2014-15	**$1,108,000**	**$251,000**	**$857,000**

FY 2015-16:	**TF**	**GF**	**FF**
DD&I (90% FF / 10% GF)	$188,000	$19,000	$169,000
M&O (75% FF / 25% GF)	$152,000	$38,000	$114,000
Software (75% FF / 25% GF)	$276,000	$69,000	$207,000
Total FY 2015-16	**$616,000**	**$126,000**	**$490,000**

Funding:
50% Title XIX / 50% GF (4260-101-0001/0890)
75% Title XIX / 25% GF (4260-101-0001/0890)
90% Title XIX / 10% GF (4260-101-0001/0890)

RATE STUDIES FOR MAIC AND AAC VENDOR

OTHER ADMIN. POLICY CHANGE NUMBER:	33
IMPLEMENTATION DATE:	1/2015
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1483

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$1,000,000	$1,000,000
STATE FUNDS	$500,000	$500,000
FEDERAL FUNDS	$500,000	$500,000

DESCRIPTION

Purpose:
This policy change estimates the cost related to hiring a contractor to survey drug price information from pharmacies.

Authority:
AB 102 (Chapter 29, Statutes of 2011)
Welfare & Institutions (W&I) Code, sections 14105.45 and 14105.451

Interdependent Policy Changes:
Not Applicable

Background:
W&I Code section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. Currently, the Department is subject to a court injunction which precludes implementation of the MAIC methodology.

AB 102 authorized the Department to develop a reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price.

To obtain information from providers necessary to establish the MAICs and AACs, the Department will hire a contractor to survey drug price information from Medi-Cal pharmacy providers and update MAICs and AACs on an ongoing basis.

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

Methodology:
1. Assume settlement of the current litigation enjoining the law is finalized prior to October 1, 2014.

2. Assume the contractors costs will be $1,000,000 TF ($500,000 GF) annually, beginning January 1, 2015.

RATE STUDIES FOR MAIC AND AAC VENDOR

OTHER ADMIN. POLICY CHANGE NUMBER: 33

3. Estimated contractors' costs are:

	FY 2014-15	FY 2015-16
Project Management Contractor	$ 270,000	$ 270,000
MAIC/AAC Vendor Contractor	$ 730,000	$ 730,000
Total	**$ 1,000,000**	**$ 1,000,000**

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

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	34
IMPLEMENTATION DATE:	5/2010
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1452

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$995,000	$750,000
STATE FUNDS	$497,500	$375,000
FEDERAL FUNDS	$497,500	$375,000

DESCRIPTION

Purpose:
This policy change estimates the upgrades to the infrastructure and ongoing costs of maintaining electronic Protected Health Information (PHI).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department acquired hardware, supplies, associated maintenance and support services that are necessary to protect and secure electronic data stored on backup systems. The data on these systems contain Medi-Cal beneficiary information that is considered confidential and/or PHI by federal and state mandates. The protection of these systems will secure and protect Department information assets from unauthorized disclosure; protect the privacy of Medi-Cal beneficiaries; prevent lawsuits from citizens for privacy violations; avoid costs to notify millions of people if a large breach does occur; and maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

The Department is continuing its effort in upgrading the backup and recovery methods for the current infrastructure by enhancing infrastructure components. The upgrade is necessary to take advantage of technologies such as backup to disk, data de-duplication, offsite data replication, and data encryption. The maintenance and increasing amount of data involved with the migration of the Department with these technologies allows the Department to continue to grow and support its virtualization infrastructure and to provide backup and recovery methods for this infrastructure.

The upgrade allows the Department to:

- Effectively and efficiently manage Department growth,
- Provide backup and recovery methods for the business programs, and
- Ensure the data is secure and managed.

Reason for Change from Prior Estimate:
The June 2014 payment was delayed and processed in August 2014.

ENCRYPTION OF PHI DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 34

Methodology:

1. The following amounts are based upon the latest projections of cost.

	TF	GF	FF
FY 2014-15:	**$995,000**	**$497,000**	**$498,000**
FY 2015-16:	**$750,000**	**$375,000**	**$375,000**

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

MITA

OTHER ADMIN. POLICY CHANGE NUMBER:	35
IMPLEMENTATION DATE:	1/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1137

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$985,000	$152,000
STATE FUNDS	$98,500	$15,200
FEDERAL FUNDS	$886,500	$136,800

DESCRIPTION

Purpose:
This policy change estimates the costs associated with the Medicaid Information Technology Architecture (MITA).

Authority:
Interagency Agreement 13-90272

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare and Medicaid Services (CMS) is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through MITA, the Department will develop the ability to streamline the process to access information from various systems, which will result in cost effectiveness. CMS will not approve Advanced Planning Documents (APDs) or provide federal funding to the Department without adherence to MITA.

The MITA information architecture includes three components; Conceptual Data Model (CDM), Logical Data Model (LDM), and data standards. The Department will build an enterprise CDM and LDM, as well as incorporate national data standards into its information technology systems. The Department will also perform business process re-engineering around MITA defined business processes. The Department recently completed its CMS required MITA State Self-Assessment (SS-A) in 2013, which included a State MITA roadmap. Annual SS-As are required by CMS.

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

Methodology:
1. Projected costs:

	TF	GF	FF
FY 2014-15	**$985,000**	**$99,000**	**$886,000**
FY 2015-16	**$152,000**	**$15,000**	**$137,000**

Funding:
90% Title XIX / 10% GF (4260-101-0001/0890)

SAN DIEGO CO. ADMINISTRATIVE ACTIVITIES

OTHER ADMIN. POLICY CHANGE NUMBER:	36
IMPLEMENTATION DATE:	7/2002
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	258

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$950,000	$950,000
STATE FUNDS	$950,000	$950,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of the contract with the County of San Diego for administrative services.

Authority:
Welfare & Institutions Code, sections 14089(g) and 14089.05

Interdependent Policy Changes:
Not Applicable

Background:
The Department contracts with the County of San Diego to provide administrative services for the San Diego Geographic Managed Care program. The Department reimburses the County for staff, postage, printing, data center access, travel, health care options presentations to explain the enrollment and disenrollment process, customer assistance and problem resolution. Effective August 2003, these services are no longer eligible for federal match. The contract term is July 1, 2007 through June 30, 2015. The Department anticipates continuing this agreement with San Diego County.

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

Methodology:
1. Based on contract provisions, the administrative activities costs will be $950,000 for FY 2014-15 and FY 2015-16.

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

COORDINATED CARE MANAGEMENT PILOT

OTHER ADMIN. POLICY CHANGE NUMBER:	37
IMPLEMENTATION DATE:	2/2010
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1125

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$884,000	$0
STATE FUNDS	$442,000	$0
FEDERAL FUNDS	$442,000	$0

DESCRIPTION

Purpose:
This policy change estimates the costs for the Coordinated Care Management (CCM) Pilot Project.

Authority:
The Budget Act of 2006

Interdependent Policy Change:
Not Applicable

Background:
The CCM Pilot Project consisted of two pilot programs designed to improve healthcare outcomes and achieve cost containment in the fee-for-service (FFS) Medi-Cal System. The CCM Pilot Project was intended to test the ability to provide more efficient care coordination in a FFS environment.

Key elements of the CCM Pilot Project included maintaining access to medically necessary and appropriate services, improving health, and providing care in a more cost-effective manner for two populations enrolled in the FFS Medi-Cal Program who were not on Medicare:

- CCM 1 - Seniors and persons with disabilities who had chronic conditions, or who may have been seriously ill and near the end of life. CCM-1 was completed with the transition of the Seniors and Persons with Disabilities population into Medi-Cal managed care health plans; and

- CCM 2 - Persons with chronic health condition(s) and serious mental illnesses (SMI). The SMI scope of work expired on July 31, 2013. This contract was amended to include Adult Day Health Care (ADHC) scope of work services to transition eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit. The CBAS scope of work was terminated in the contract on July 31, 2013 with the transition of services to the Department's Long Term Care Division.

The Department entered into two contracts with APS Healthcare to implement the CCM Pilot Project. CCM 1 began operations in January 2010, with payments for services beginning in February 2010. CCM 2 began operations in April 2010, with payments for services beginning in May 2010.

The contract term for CCM 1 was from March 1, 2009 to December 31, 2012. The contract term for CCM 2 was from August 20, 2009 to August 31, 2014. However, the CCM 2 contract terminated 13 months earlier on July 31, 2013. The contract term for the University of California, Los Angeles (UCLA) independent evaluation (IE) is from July 1, 2012 through June 30, 2015.

COORDINATED CARE MANAGEMENT PILOT

OTHER ADMIN. POLICY CHANGE NUMBER: 37

ADHC FFS Assessment and Care Coordination costs are reflected in the ADHC Transition Administration policy change.

Reason for Change from Prior Estimate:
The FY 2014-15 costs include carryover costs for FY 2013-14 evaluations plus final invoices in FY 2014-15.

Methodology:
1. The following chart shows FY 2014-15 costs:

FY 2014-15	TF	GF	FF
CCM1	$448,000	$224,000	$224,000
CCM2	$318,000	$159,000	$159,000
UCLA IE	$118,000	$59,000	$59,000
Total	**$884,000**	**$442,000**	**$442,000**

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

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER:	38
IMPLEMENTATION DATE:	7/2009
ANALYST:	Andrew Yoo
FISCAL REFERENCE NUMBER:	266

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$856,000	$856,000
STATE FUNDS	$428,000	$428,000
FEDERAL FUNDS	$428,000	$428,000

DESCRIPTION

Purpose:
This policy change estimates the administrative costs of contracting for annual independent audits of the Disproportionate Share Hospital (DSH) program.

Authority:
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)
Title 42, Code of Federal Regulations, section 455.300 et. seq.

Interdependent Policy Changes:
Not Applicable

Background:
The MMA requires an annual independent certified audit that primarily certifies:

1. The extent to which DSH hospitals (approximately 150+ hospitals) have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under section 1923 of the MMA.

2. That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

The audits will be funded with 50% Federal Financial Participation and 50% General Fund (GF). The Centers for Medicare and Medicaid Services (CMS) released the final regulation and criteria for the annual certified audit in 2008. Each fiscal year's annual audit and report is due to CMS by December 31.

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

Methodology:
1. Each fiscal year, all auditing activity will cost $856,000 ($428,000 GF).

2. In FY 2014-15, the Department will make final payment for the FY 2010-11 audit and partial payment for the FY 2011-12 audit.

3. In FY 2015-16, the Department will make final payment for the FY 2011-12 audit and partial payment for the FY 2012-13 audit.

MMA - DSH ANNUAL INDEPENDENT AUDIT

OTHER ADMIN. POLICY CHANGE NUMBER: 38

	TF	GF	FF
FY 2014-15	**$856,000**	**$428,000**	**$428,000**
FY 2015-16	**$856,000**	**$428,000**	**$428,000**

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

ACA EXPANSION ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	39
IMPLEMENTATION DATE:	9/2013
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1795

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$828,000	$517,000
STATE FUNDS	$414,000	$258,500
FEDERAL FUNDS	$414,000	$258,500

DESCRIPTION

Purpose:
This policy change estimates the contract costs for implementing required provisions of the Affordable Care Act (ACA).

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Effective January 1, 2014, Medi-Cal eligibility expanded to include individuals between the ages of 19 up to 65 (primarily childless adults) with incomes up to 138% of the federal poverty level based on modified adjusted gross income. The Department expects this optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. These mandatory requirements will encourage many individuals who are currently eligible but not enrolled to enroll in Medi-Cal. This policy change estimates the contract costs associated with IT consultant services and actuarial work related to rate development.

IT consultant services include:

- Providing technical expertise in preparing test cases, scenarios, data, and documentation,
- Ensuring quality controls are adhered to prior to implementing system changes,
- Coordinating quality assurance activities, enterprise testing, release management, and other levels of system testing,
- Providing technical assistance for the Department.

Reason for Change from Prior Estimate:
Estimated actuarial costs in FY 2014-15 were reduced based on actual FY 2013-14 invoices.

Methodology:
1. The Department estimates IT consultant services and actuarial costs for the new ACA expansion population are:

ACA EXPANSION ADMIN COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 39

(Dollars in Thousands)	FY 2014-15			FY 2015-16		
	TF	**GF**	**FF**	**TF**	**GF**	**FF**
Rate Development	$517	$258.5	$258.5	$517	$258.5	$258.5
IT Consultant Services	$311	$155.5	$155.5	$0	$0	$0
Total	**$828**	**$414**	**$414**	**$517**	**$258.5**	**$285.5**

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

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER:	40
IMPLEMENTATION DATE:	7/1996
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	240

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$658,000	$682,000
STATE FUNDS	$329,000	$341,000
FEDERAL FUNDS	$329,000	$341,000

DESCRIPTION

Purpose:
This policy changes estimates the Third Party Liability postage and printing costs.

Authority:
Government Code 7295.4
AB 155 (Chapter 820, Statutes of 1999)

Interdependent Policy Changes:
Not Applicable

Background:
The Department uses direct mails and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms printed and mailed, as well as the number of reports received, correlates to the Medi-Cal caseload.

All forms related to Medicare Operations are available online. The Department purchased a document folder/inserter machine in FY 2012-13 to automate the mailings done in-house.

Reason for Change from Prior Estimate:
The FY 2014-15 postage and printing costs have increased as a result of the increase in the Medi-Cal population due to expanded Medi-Cal eligibility.

Methodology:
1. The cost breakdown is shown below:

FY 2014-15	Postage	Printing	Total
Personal Injury	$183,000	$34,000	$217,000
Estate Recovery	$176,000	$244,000	$420,000
Overpayments	$5,000	$1,000	$6,000
Cost Avoidance	$5,000	$1,000	$6,000
*AB 155 Invoices	$7,000	$0	$7,000
**Document Folder Inserter	$0	$0	$2,000
Total	**$376,000**	**$280,000**	**$658,000**

POSTAGE AND PRINTING - THIRD PARTY LIAB.

OTHER ADMIN. POLICY CHANGE NUMBER: 40

FY 2015-16	Postage	Printing	Total
Personal Injury	$192,000	$35,000	$227,000
Estate Recovery	$185,000	$249,000	$434,000
Overpayments	$5,000	$1,000	$6,000
Cost Avoidance	$5,000	$1,000	$6,000
*AB 155 Invoices	$7,000	$0	$7,000
**Document Folder Inserter	$0	$0	$2,000
Total	**$394,000**	**$286,000**	**$682,000**

*AB 155 requires invoicing for premiums for the 250% Working Disabled Program.

** Cost of maintenance agreement for the Document Folder Inserter used to process mailings in-house.

2. The estimated postage and printing costs are:

	TF	GF	FF
FY 2014-15:	**$658,000**	**$329,000**	**$329,000**
FY 2015-16:	**$682,000**	**$341,000**	**$341,000**

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

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER:	41
IMPLEMENTATION DATE:	12/2014
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1774

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$605,000	$883,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$605,000	$883,000

DESCRIPTION

Purpose:
This policy change estimates the payments to the California Department of Public Health (CDPH) to improve delivery of Vital Records data.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
California birth, death, fetal death, still birth, marriage and divorce records are maintained by the CDPH Vital Records. Information collected in these records is necessary to support core functions of the Department as represented in the Medicaid Information Technology Architecture (MITA) business functions. The MITA—a Centers for Medicare and Medicaid Services (CMS) initiative—fosters an integrated business and information technology (IT) transformation across the Medicaid enterprise in an effort to improve the administration and operation of the Medicaid program.

Historically, the Department has received Vital Records data from CDPH in a case-by-case and manual manner. In order to improve efficiency and advance MITA maturity, the Department is requesting enhanced Federal Financial Participation (FFP) to establish automated and timely processes to receive Vital Record data from CDPH.

Reason for Change from Prior Estimate:
Due to delays in approvals and contract, the start date changed from May 2014 to October 2014 with first records being exchanged in December 2014.

Methodology:
1. Assume the Department and CDPH will receive MITA 90% FFP for Design, Development, and Installation activities and 75% FFP for ongoing costs to deliver data in an automated fashion.

2. Assume CDPH will provide the match for FFP from the Health Statistics Special Fund (HSSF).

3. Assume that establishing an automated data interchange will cost $100,000 with 90% FFP.

4. Assume a data flow based on a monthly average of 20,000 death records and 45,000 birth records.

VITAL RECORDS DATA

OTHER ADMIN. POLICY CHANGE NUMBER: 41

5. Assume that ongoing cost for each record will be $1.51 to reimburse the cost associated with preparing the record for transfer and transferring the record to the Department.

   For FY 2014-15
   $1.51 per record x (20,000 death records + 45,000 birth records) x 7 months (December 2014-June 2015) = $1,115,000

   For FY 2015-16
   $1.51 per record x (20,000 death records + 45,000 birth records) x 12 months = $1,177,800

FY 2014-15	**HSSF**	**FFP**	**Total**
Data Interchange Development	$10,000	$90,000	$100,000
Data Provision	$172,000	$515,000	$687,000
Total	$182,000	**$605,000**	$787,000

FY 2015-16	**HSSF**	**FFP**	**Total**
Data Provision	$295,000	$883,000	$1,178,000
Total	$295,000	**$883,000**	$1,178,000

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

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	42
IMPLEMENTATION DATE:	4/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1556

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$581,000	$200,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$581,000	$200,000

DESCRIPTION

Purpose:
This policy change budgets the federal funding to cover administrative costs for increasing the California Community Transitions (CCT) enrollment.

Authority:
Money Follows the Person Rebalancing Demonstration (42 USC 1396a)
Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
Affordable Care Act (ACA) (P.L. 111-148), Section 2403

Interdependent Policy Changes:
Not Applicable

Background:
Pursuant to the ACA, on September 3, 2010 the Centers for Medicare and Medicaid Services (CMS) authorized the Department to draw down $750,000 in Money Follows the Person (MFP) Rebalancing Demonstration supplemental grant funding. The Department allocated the supplemental grant funding to implement an assessment tool to improve the ability of Skilled Nursing Facilities/Nursing Facilities, states, and other qualified entities to identify individuals who are interested in returning to the community. The Department is collaborating with the Aging and Disability Resources Connection (ADRC) programs, CCT lead organizations, and other community-based providers to increase CCT enrollment. This supplemental grant funding does not require matching funds. The costs were 100% federally funded.

CMS granted the Department an extension of this grant through September 2014 to complete the objectives set forth in the grant. The supplemental grant expired on September 30, 2014, however the remaining funds continue to be available under the overall MFP grant, with federal financial participation (FFP) determined by use of the funds.

Beginning on October 1, 2014, the Department will allocate MFP grant funding to continue efforts that were initiated under the supplemental grant to increase CCT enrollment. To accomplish this objective, DHCS has entered into a contract with California State University, Sacramento (CSUS) to develop marketing and outreach materials to increase beneficiary awareness of the CCT program. The Department will also contract with CSUS to plan and facilitate four one-day summits for the purpose of encouraging increased local contact agency participation in the CCT program and developing CCT partnerships with housing developers, health plans and waiver providers. These activities qualify as administrative marketing and outreach activities, which are 100% federally funded through the MFP grant.

CCT OUTREACH - ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 42

Reason for Change from Prior Estimate:
Upon conclusion of the supplemental grant, administrative support activities to increase CCT enrollment continue under the general MFP grant.

Methodology:

1. Costs began in April 2011 totaling approximately $11,000 FFP during FY 2010-11; approximately $11,000 in FY 2012-13; and approximately $202,400 paid in FY 2013-14.

2. Assume $140,000 will be paid under the supplemental grant in September 2014. The remaining $385,600 continues to be available under the MFP grant based on established FFP for the Demonstration.

3. Assume $441,000 will be paid between October 2014 and June 2015 for marketing/outreach and summits. An additional $200,000 is expected to be paid in FY 2015-16 for similar activities.

4. Estimated costs are based on proposed expenditures for the following activities:

    - Minimum Data Set (MDS) 3.0 Section Q options referrals systems,
    - ADRC planning and start-up implementation,
    - ADRC/MFP collaborative strategic planning,
    - MDS 3.0 Section Q referrals policy development,
    - MDS/Options counseling training sessions,
    - LTSS MFP advisory group,
    - Marketing and outreach mail campaign, and
    - MFP quarterly summits.

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

THIRD PARTY VALIDATION OF CERTIFIED PROVIDERS

OTHER ADMIN. POLICY CHANGE NUMBER:	43
IMPLEMENTATION DATE:	12/2013
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1830

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$250,000	$0
STATE FUNDS	$125,000	$0
FEDERAL FUNDS	$125,000	$0

DESCRIPTION

Purpose:
This policy change estimates vendor costs to conduct a third party validation of all Drug Medi-Cal (DMC) program service providers, pre and post certification.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The third party validation will enhance anti-fraud activities that will enable the Department to assess program providers, provider risk, demographic coverage, and generate alerts of changes in status by matching providers through various sources of information. Matching sources will include but are not limited to (a) Federal Exclusion Records; (b) State Exclusion Records; (c) Federal Death Records; (d) State Licensure Sanctions; and (e) National Provider Identification (NPI) Deactivations.

The Department allocated $250,000 in FY 2013-14 and $250,000 in FY 2014-15 for provider validation.

Reason for Change from Prior Estimate:
Contract payments were delayed from FY 2013-14 to FY 2014-15 due to the need for a new contract.

Methodology:
1. The contractor started providing services December 1, 2013.

2. The total contract cost is $500,000.

3. Assume $250,000 will be spent in FY 2014-15.

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

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER:	44
IMPLEMENTATION DATE:	6/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1739

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$247,000	$247,000
STATE FUNDS	$61,750	$61,750
FEDERAL FUNDS	$185,250	$185,250

DESCRIPTION

Purpose:
This policy change estimates the cost of a Certified Project Manager (CPM) assisting in the development of a Planning Advanced Planning Document (PAPD) and managing the project to procure a new Medi-Cal Dental Fiscal Intermediary Contract.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Centers for Medicare & Medicaid Services (CMS) determined the new dental Fiscal Intermediary (FI) contract no longer meets the regulatory criteria and conditions as a Medicaid Management Information System (MMIS) acquisition. Therefore, the contract is not eligible for enhanced federal funding. The Department has procured a CPM. The CPM will work closely with the Medi-Cal Dental Services Division (MDSD) program management and staff, CMS, and key stakeholders. The Department and CPM has developed a PAPD to ensure the CD-MMIS is in compliance with federal regulations and eligible for enhanced federal funding. The PAPD was approved by CMS in July of 2014.

The CPM consultant is responsible for performing the full range of project management functions for the duration of this project including:

- Resource planning,
- Contract development and management,
- Risk management,
- Project reporting,
- Fiscal monitoring and reporting,
- Issue management,
- Performing a marketplace analysis of the vendor community and identify procurement alternatives and recommendations for the procurement of a new dental FI contract,
- Developing a complete and thorough PAPD that meets the regulatory criteria and conditions as a MMIS and to ensure the PAPD is developed timely and approval by CMS is obtained, and
- Assisting Department staff in responding to CMS inquiries and provide additional documentation if required.

DENTAL PAPD PROJECT MANAGER

OTHER ADMIN. POLICY CHANGE NUMBER: 44

Reason for Change from Prior Estimate:
The increase is due to updates in the additional time and costs needed for the procurement effort. General Fund (GF) is now at 25% of the total cost rather than 50%.

Methodology:
1. The project manager was hired in June 2013 and the contract will end June 2016.

2. Total estimated costs are $629,000.

3. Payments began in June 2013.

	TF	GF	FF
FY 2014-15	**$247,000**	**$62,000**	**$185,000**

	TF	GF	FF
FY 2015-16	**$247,000**	**$62,000**	**$185,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER:	45
IMPLEMENTATION DATE:	10/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1590

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$240,000	$0
STATE FUNDS	$120,000	$0
FEDERAL FUNDS	$120,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of a contract with the University of Massachusetts (UMASS) to identify potential overpayments to Centers for Medicare and Medicaid Services (CMS) or Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles.

Authority:
Welfare & Institutions Code 14124.92
Contract 10-87134 A01

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into a three-year contract with UMASS on October 1, 2010. UMASS assists the Department in auditing the invoices received from CMS to pay the Medicare premiums. On May 17, 2012, the Department of General Services approved extending the agreement to June 30, 2015. The Department does not plan to extend this contract for FY 2015-16.

The payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers. These payments are 10% of the amounts recovered.

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

Methodology:
1. The cost of the contractor is 10% of the amount recovered.

2. For FY 2014-15, the case projections from UMASS assume fewer cases will be discovered for recovery.

3. Assume the annual amount recovered will be $2,400,000 for FY 2014-15.

4. Assume the cost of the contractor will be $240,000 in FY 2014-15.

   $2,400,000 x 10% = $240,000 annual contractor cost for FY 2014-15

MEDICARE BUY-IN QUALITY REVIEW PROJECT

OTHER ADMIN. POLICY CHANGE NUMBER: 45

	TF	GF	FF
FY 2014-15	**$400,000**	**$ 200,000**	**$200,000**

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

DMHC INTER-AGENCY AGREEMENT - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER:	46
IMPLEMENTATION DATE:	11/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1815

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$189,000	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$189,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of an inter-agency agreement (IAA) with the California Department of Managed Health Care (DMHC) to assist the Department in its monitoring of dental plans.

Authority:
Interagency Agreement 13-90172

Interdependent Policy Changes:
Not Applicable

Background:
SB 853 (Chapter 717, Statues of 2010) authorized the Department to enter into an inter-agency agreement with DMHC to confirm compliance with the Medi-Cal contract by conducting financial audits, dental surveys, and a review of the provider networks of the managed care plans participating in its Medi-Cal line of business.

This policy change estimates the federal reimbursement for DMHC costs to perform the above functions.

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

Methodology:
1. The DMHC IAA was effective September 2013.
2. The reimbursement of DMHC costs began in September 2013.
3. Assume the federal share of personnel costs are $97,000 in FY 2014-15.
4. Assume the federal share of operating expenses (travel, subcontracts, and training) costs are $92,000 in FY 2014-15.
5. The FFP portion of the cost is reimbursable to DMHC per the IAA.
6. The costs for this contract will be included in the State Support budget beginning in FY 2015-16.

DMHC INTER-AGENCY AGREEMENT - ADMIN

OTHER ADMIN. POLICY CHANGE NUMBER: 46

	Personnel Costs (FF)	Operating Expenses (FF)	FF Total
FY 2014-15	$ 97,000	$ 92,000	$ 189,000

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

ANNUAL EDP AUDIT CONTRACTOR

OTHER ADMIN. POLICY CHANGE NUMBER:	47
IMPLEMENTATION DATE:	8/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1734

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$162,000	$162,000
STATE FUNDS	$81,000	$81,000
FEDERAL FUNDS	$81,000	$81,000

DESCRIPTION

Purpose:
This policy change estimates the cost related to procuring an annual Electronic Data Processing (EDP) auditor of the Medi-Cal fiscal intermediary.

Authority:
Title 45, Code of Federal Regulations 95.621
Contract 09-86210

Interdependent Policy Changes:
Not Applicable

Background:
Title 45, Code of Federal Regulations 95.621 requires the Department to conduct periodic onsite surveys and reviews of EDP methods and practices. The survey determines the adequacy of EDP methods and practices. Federal regulations require the Department to develop a schedule between the Department and State or local agencies prior to conducting such surveys or reviews. In addition, the Medi-Cal Fiscal Intermediary contract requires the Department to procure an audit contractor to perform an annual EDP audit. The Department currently provides this annual audit to the Bureau of State Audits to incorporate into the Single State Federal Compliance Audit for the Medicaid program.

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

Methodology:
1. The estimate is based on actual bid amounts.

	TF	GF	FF
FY 2014-15:	**$162,000**	**$81,000**	**$81,000**

	TF	GF	FF
FY 2015-16:	**$162,000**	**$81,000**	**$81,000**

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

CCS PROGRAM PILOTS EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER:	48
IMPLEMENTATION DATE:	7/2014
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1872

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$150,000	$150,000
STATE FUNDS	$75,000	$75,000
FEDERAL FUNDS	$75,000	$75,000

DESCRIPTION

Purpose:
This policy change estimates the costs associated with an independent evaluation of the California Children's Services (CCS) Program Pilot.

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:
Not Applicable

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.

The Department has a contract with the University of California, Los Angeles (UCLA) for an independent evaluation of the CCS Program Pilot. The policy change titled California Children's Services (CCS) Program Pilots budgets the cost of implementing the program pilot. This policy change budgets the other administration.

Reason for Change from Prior Estimate:
This is a new policy change. The other administrative expenditures from the CCS Program Pilots policy change have been separated and accounted for in this policy change.

Methodology:
The Department's contract with UCLA for the independent evaluation of the CCS Program Pilots has negotiated contract costs of $150,000 annually.

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

MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION

OTHER ADMIN. POLICY CHANGE NUMBER:	49
IMPLEMENTATION DATE:	3/2015
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1868

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$125,000	$125,000
STATE FUNDS	$62,500	$62,500
FEDERAL FUNDS	$62,500	$62,500

DESCRIPTION

Purpose:
This policy change estimates the cost for an independent vendor to perform the Medicaid and Children's Health Insurance Program (CHIP) Eligibility Review Pilots test certifications required by the Centers for Medicaid and Medicare (CMS) for the new CalHEERS eligibility determination system.

Authority:
State Health Official (SHO) letter # 13-005

Interdependent Policy Changes:
Not Applicable

Background:
The Affordable Care Act (ACA) brought significant changes to the way the states adjudicated eligibility for applicants for Medicaid and CHIP. Changes included the use of the Modified Adjusted Gross Income (MAGI) methodology for income determinations and household compositions, the use of a single streamlined application, availability of multiple channels for submitting application information, and the need for data sharing and account transfers between the Marketplace, Medicaid and CHIP. To assess these changes, CMS implemented an interim change in methodology for conducting eligibility reviews. The State Health Official Letter 13-005, issued on August 15, 2013, directs states to implement four Medicaid and CHIP Eligibility Review Pilots in place of the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) eligibility review requirements for fiscal years (FY) 2014-2016. These pilots will provide more targeted, detailed information on the accuracy of eligibility determinations using the new ACA rules, and provide states and CMS with critical feedback. CMS has not given specific guidance regarding the process for certifying the test cases for the second pilot but has stated that an independent vendor must certify the pilot test results prior to its submission. If this is not implemented the Department would be non-compliant with CMS program requirements and could be subject to monetary fines or sanctions.

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

Methodology:
Based upon current California Multiple Award Schedule (CMAS) pricing for consultant contracts, the contract will be approximately $125,000 (TF) for FY 2014-15, and $125,000 (TF) for FY 2015-16.

MAGI-CHIP QUALITY CONTROL TEST CERTIFICATION

OTHER ADMIN. POLICY CHANGE NUMBER: 49

	FY 2014-15			FY 2015-16		
	TF	GF	FF	TF	GF	FF
Ongoing Cost	$125,000	$62,500	$62,500	$125,000	$62,500	$62,500

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

EPOCRATES

OTHER ADMIN. POLICY CHANGE NUMBER:	50
IMPLEMENTATION DATE:	4/2007
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1157

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$107,000	$107,000
STATE FUNDS	$53,500	$53,500
FEDERAL FUNDS	$53,500	$53,500

DESCRIPTION

Purpose:
This policy change estimates the cost of a contract with Epocrates Rx™.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
Epocrates Rx™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country.

The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) and up to three other departmental "formularies", for example, Family PACT or AIDS Drug Assistance Program (ADAP), in the Epocrates system for access by subscribers.

Epocrates provides the Department with an opportunity to reach a large network of health professionals via a unique point-of-care clinical reference solution for physicians and other health professionals accessible on both handheld devices and Internet based desktop computers.

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

Methodology:
1. According to the contract, the annual amount paid to Epocrates for their services is $107,000.

Fiscal Year	Expenditures
FY 2013-14	$107,000
FY 2014-15	**$107,000**
FY 2015-16	**$107,000**
FY 2016-17	$ 9,000

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

MIS/DSS CONTRACT REPROCUREMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	51
IMPLEMENTATION DATE:	7/2013
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1615

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$104,000	$0
STATE FUNDS	$26,000	$0
FEDERAL FUNDS	$78,000	$0

DESCRIPTION

Purpose:
This policy change estimates the cost related to hiring a contractor to assess the services to be included in the Management Information System and Decision Support System (MIS/DSS) contract.

Authority:
State Administrative Manual 4821
Title 45, Code of Federal Regulations 95.611

Interdependent Policy Changes:
Not Applicable

Background:
The contract for ongoing development, maintenance, and operation of the MIS/DSS is scheduled to end on June 30, 2015. The Department hired a vendor to provide assistance with the reassessment of the scope of services to be included in the reprocurement of the MIS/DSS contract. The contractor began work on January 14, 2013. Resources are needed to develop the Invitation for Bid (IFB) and the Advance Planning Document (APD) to achieve required state and federal level approvals. The vendor will provide services through January 2015.

Reason for Change from Prior Estimate:
The change is due to the majority of the project being completed in FY 2013-14.

Methodology:
1. The estimated costs for FY 2014-15 are:

	TF	GF	FF
FY 2014-15:	**$104,000**	**$26,000**	**$78,000**

Funding:
75% Title XIX / 25% GF (4260-101-0001/0890)

CCS CASE MANAGEMENT SUPPLEMENTAL PAYMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	52
IMPLEMENTATION DATE:	7/2012
ANALYST:	Toni Richardson
FISCAL REFERENCE NUMBER:	1388

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$100,000	$100,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$100,000	$100,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for county funds expended above the CCS Case Management allocations on administrative activities in support of a county's California Children's Services (CCS) Medi-Cal caseload using Certified Public Expenditures (CPE).

Authority:
California Health & Safety Code § 123955(f)
Code of Federal Regulations, Title 42, 433.51

Interdependent Policy Changes:
Not Applicable

Background:
County costs for determination of CCS Medi-Cal eligibility, care coordination, utilization management and prior authorization of services are reimbursed by Medi-Cal. County funds expended above the allocations on administrative activities in support of a county's CCS Medi-Cal caseload may be used as CPE to draw down Title XIX federal financial participation (FFP).

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

Methodology:
1. It is assumed that $100,000 will be drawn down with counties' CPE in FY 2014-15 and FY 2015-16.

	FFP
FY 2014-15	**$100,000**
FY 2015-16	**$100,000**

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

TAR POSTAGE

OTHER ADMIN. POLICY CHANGE NUMBER:	53
IMPLEMENTATION DATE:	7/2003
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	267

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$71,000	$66,000
STATE FUNDS	$35,500	$33,000
FEDERAL FUNDS	$35,500	$33,000

DESCRIPTION

Purpose:
This policy change estimates postage costs for Medi-Cal Treatment Authorization Requests (TAR).

Authority:
Welfare & Institutions Code, section 14103.6

Interdependent Policy Changes:
Not Applicable

Background:
Not Applicable

Reason for Change from Prior Estimate:
The estimated expenditures will decrease due to the transition to the e-TAR system.

Methodology:
1. TAR postage costs for Medi-Cal are assumed to be $71,000 for FY 2014-15 based on actual expenditures (July 2013 through June 2014).

2. For FY 2015-16, the costs for TAR postage are expected to be $66,000.

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

Q5i AUTOMATED DATA SYSTEM ACQUISTION

OTHER ADMIN. POLICY CHANGE NUMBER:	54
IMPLEMENTATION DATE:	8/2011
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1440

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$59,000	$59,000
STATE FUNDS	$29,500	$29,500
FEDERAL FUNDS	$29,500	$29,500

DESCRIPTION

Purpose:
This policy change estimates the cost of the Q5i automated data system and the ongoing support costs.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance, and support. The Q5i system supports quality control efforts for federally mandated programs. As a result of implementation of the Affordable Care Act, the Centers for Medicare and Medicaid Services issued guidance to states that ended previous quality control programs and implements a series of four new pilot programs, that will replace MEQC and PERM, to be conducted over federal fiscal years 2014 – 2016. Q5i will need to be modified to accommodate the new federal requirements over this three year period. A contract is required for maintenance and system support costs.

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

Methodology:
1. Ongoing costs began in March 2012.

2. These estimates are provided by the vendor.

	FY 2014-15			FY 2015-16		
	TF	GF	FF	TF	GF	FF
Ongoing Cost	$59,000*	$29,500	$29,500	$59,000*	$29,500	$29,500

*Rounded

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

KATIE A. V. DIANA BONTA SPECIAL MASTER

OTHER ADMIN. POLICY CHANGE NUMBER:	55
IMPLEMENTATION DATE:	7/2009
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1453

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$50,000	$0
STATE FUNDS	$25,000	$0
FEDERAL FUNDS	$25,000	$0

DESCRIPTION

Purpose:
This policy change estimates the special master costs for the *Katie A. v. Diana Bontá* lawsuit settlement.

Authority:
Katie A. v Diana Bontá lawsuit settlement

Interdependent Policy Changes:
Not Applicable

Background:
On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*. The preliminary injunction required the provision of the Early and Periodic Screening, Diagnosis and Treatment program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to the District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval. On October 13, 2011, the parties began a new series of Special Master meetings to develop a plan for, and begin, settlement implementation. The court granted final approval of the proposed settlement on December 2, 2011. The Department and the California Department of Social Services (CDSS) fund the Special Master. As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive an increase in existing services that will be provided in a more intensive and effective manner. Court jurisdiction will end December 1, 2014. The services of the special master are expected to continue through January 2015.

Reason for Change from Prior Estimate:
Special master costs are anticipated to be lower.

Methodology:
1. Assume the new Special Master costs are $100,000 for FY 2014-15.

2. The Special Master costs will be split with CDSS and each department will pay 50% of the costs.

KATIE A. V. DIANA BONTA SPECIAL MASTER

OTHER ADMIN. POLICY CHANGE NUMBER: 55

	TF	CDSS TF	DHCS TF
FY 2014-15	$100,000	$50,000	$50,000

3. The Department's estimated costs for FY 2014-15 are:

	DHCS TF	GF	FFP
FY 2014-15	**$50,000**	**$25,000**	**$25,000**

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

PEDIATRIC PALLIATIVE CARE WAIVER EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER:	56
IMPLEMENTATION DATE:	7/2010
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	1335

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$39,000	$0
STATE FUNDS	$19,500	$0
FEDERAL FUNDS	$19,500	$0

DESCRIPTION

Purpose:
This policy change estimates the costs associated with an evaluation of the Pediatric Palliative Care Waiver Pilot Project.

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

Interdependent Policy Changes:
Not Applicable

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

AB 1745 mandated the Department to evaluate the pilot project through an independent evaluator to meet federal assurances. The independent evaluation is in progress with final data collection on October 1, 2013. The report plans to be completed and submitted by December 31, 2014.

Reason for Change from Prior Estimate:
The evaluation report was finalized in FY 2014-15, requiring the final payment to be withheld until work was complete.

Methodology:
Payment to the independent evaluator is scheduled to be made in January 2015.

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

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER:	57
IMPLEMENTATION DATE:	7/2015
ANALYST:	Julie Chan
FISCAL REFERENCE NUMBER:	1757

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$0	$9,370,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$9,370,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the interim and final cost settlements on specialty mental health services (SMHS) administrative expenditures.

Authority:
Welfare & Institution Code 14705(c)

Interdependent Policy Changes:
Not Applicable

Background:
The Department reconciles interim payments to county cost reports for mental health plans (MHPs) for utilization review/quality assurance (UR/QA), mental health Medi-Cal administrative activities (MH MAA), and administration. The Department completes these interim settlements within two years of the end of the fiscal year. Final settlements are completed within three years of the last amended cost report the county MHPs submit to the Department.

The reconciliation process for each fiscal year may result in an overpayment or an underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will reimburse the federal funds.

Reason for Change from Prior Estimate:
No cost settlements will be finalized in FY 2014-15.

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.
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, UR/QA, and MH MAA are each determined separately.

INTERIM AND FINAL COST SETTLEMENTS-SMHS

OTHER ADMIN. POLICY CHANGE NUMBER: 57

(Dollars in Thousands)

Interim Settlements

FY 2009-10	Underpaid	Overpaid	Net FF
SMH Admin	$8,235	($3,078)	$5,157
MCHIP*	$329	$0	$329
UR/QA	$2,419	($299)	$2,120
MH MAA	$977	$0	$977
HFP Admin*	$787	$0	$787
Total FY 2015-16	$12,747	($3,377)	**($9,370)**

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

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER:	58
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1856

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$51,560,000	$38,370,000
STATE FUNDS	$25,394,050	$18,897,750
FEDERAL FUNDS	$26,165,950	$19,472,250

DESCRIPTION

Purpose:
This policy change estimates the operational costs of the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Operations for the current HCO contract with MAXIMUS began on January 1, 2009, for three years and nine months with three one-year optional extension years, plus an Extended Operations Period. Funds paid on the contract use a mixture of federal funds and general funds (50/50 for Administration; 75/25 for Children's Health Insurance Program Reauthorization Act; and 65/35 for Medicaid Expansion Children's Health Insurance Program).

Operational costs are the routine expenses incurred by HCO's operations such as:

- Transactions – Enrollment or disenrollment processing activities and transactions with the Department.
- Mailings – Mailings include initial informing, re-informing, monthly reconciliation, and annual re-notification mailings.
- Beneficiary Dental Exception (BDE) Mailings – Mailings to dental beneficiaries in Sacramento County for exception to plan enrollment.
- Beneficiary Direct Assistance/Call Center – Telephone Call Center (TCC) agent informing and enrollment assistance to Medi-Cal applicants/beneficiaries and/or their authorized representatives in understanding, selecting, and using managed care medical and dental plans. In addition, the TCC assists providers, health plans, and counties or other interested parties who request information regarding the HCO program and/or Medi-Cal managed care.
- Personalized Provider Directory (PPD) Project– Fixed price costs for the PPD Project.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

- Seniors and Persons with Disabilities (SPD) County Inserts – Incremental Costs – Special inserts for SPD informing packets.
- Medi-Cal Publications Management Services – Publication management services for the development, revision, reproduction, and distribution of Medi-Cal publications that do not pertain to HCO informing materials.
- Initial Health Screen Questionnaire - Health Information Form (HIF) - The purpose of the HIF is to ensure applicants/beneficiaries with existing disabilities or with chronic conditions identify themselves to assure timely access to care. The HIFs are distributed and processed to be mailed with the HCO informing packet and are also available at Enrollment Service Representatives presentation sites.
- Coordinated Care Initiative (CCI) Booklets – Incremental Cost – Special CCI informing packets.
- Base Volume Increase Projection - The estimated cost for the entire infrastructure necessary for HCO Operations for occurrences when current base contract volumes are exceeded from additional and new projects.
- Prior Year Unpaid Invoices - Prior year unpaid invoices will be accrued and paid in the following fiscal year.

Reason for change from Prior Estimate:

- The BDE projects costs are now included in the HCO Operations costs and the number of beneficiaries has increased.
- The CCI booklets – incremental costs have been shifted from HCO Operations to the CCI – Cal MediConnect and Managed Long Term Care Support Services policy change.
- Additionally, the prior year unpaid invoices will be accrued and paid in FY 2014-15.

Methodology:

1. Operations costs are fixed price rates based on volumes within minimum and maximum ranges under the HCO contract.

2. Prior year unpaid invoices for May and June of FY 2013-14 will be paid in FY 2014-15 for a total of $13,746,000.

3. In FY 2014-15, the BDE projects costs will now roll into the HCO Operations fixed price costs, with an increase in the number of beneficiaries, for a total of $344,000.

4. In FY 2014-15, the CCI booklets – incremental costs, $931,000 have been shifted from HCO Operations fixed price costs to the CCI – Cal MediConnect and Managed Long Term Care Support Services policy change.

HCO OPERATIONS

OTHER ADMIN. POLICY CHANGE NUMBER: 58

FY 2014-15	TF	GF Title XIX (50%)	GF Title XXI (35%)	FF Title XIX (50%)	FF Title XXI (65%)
Transactions	$10,435,000	$4,956,000	$183,000	$4,957,000	$339,000
Packet Mailings	$7,562,000	$3,592,000	$132,000	$3,592,000	$246,000
BDE Packet Mailings	$344,000	$163,000	$6,000	$164,000	$11,000
BDA/Call Center	$4,662,000	$2,214,000	$82,000	$2,215,000	$151,000
PPD	$444,000	$211,000	$8,000	$211,000	$14,000
SPD Inserts	$64,000	$32,000	$0	$32,000	$0
Medi-Cal Publications	$385,000	$183,000	$7,000	$183,000	$12,000
HIF	$169,000	$80,000	$3,000	$81,000	$5,000
CCI Booklets	$0	$0	$0	$0	$0
Base Volume Increase	$13,749,000	$6,531,000	$240,000	$6,531,000	$447,000
Prior Year Unpaid invoices	$13,746,000	$6,529,000	$240,000	$6,530,000	$447,000
Total	**$51,560,000**	**$24,491,000**	**$901,000**	**$24,496,000**	**$1,672,000**

FY 2015-16	TF	GF Title XIX (50%)	GF Title XXI (35%)	FF Title XIX (50%)	FF Title XXI (65%)
Transactions	$10,664,000	$5,065,000	$187,000	$5,066,000	$346,000
Packet Mailings	$7,857,000	$3,732,000	$138,000	$3,732,000	$255,000
BDE Packet Mailings	$183,000	$87,000	$3,000	$87,000	$6,000
BDA/Call Center	$4,824,000	$2,426,000	$84,000	$2,157,000	$157,000
PPD	$458,000	$217,000	$8,000	$218,000	$15,000
SPD Inserts	$67,000	$33,000	$0	$34,000	$0
Medi-Cal Publications	$394,000	$187,000	$7,000	$187,000	$13,000
HIF	$174,000	$82,000	$3,000	$83,000	$6,000
CCI Booklets	$0	$0	$0	$0	$0
Base Volume Increase	$13,749,000	$6,531,000	$240,000	$6,531,000	$447,000
Prior Year Unpaid invoices	$0	$0	$0	$0	$0
Total	**$38,370,000**	**$18,360,000**	**$670,000**	**$18,095,000**	**$1,245,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO CCI - CAL MEDICONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER:	59
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1860

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$42,175,000	$16,136,000
STATE FUNDS	$21,087,500	$8,068,000
FEDERAL FUNDS	$21,087,500	$8,068,000

DESCRIPTION

Purpose:
This policy change estimates the costs for the specialized call center and informing materials to transition dually eligible and Medi-Cal only beneficiaries into managed care health plans under the Coordinated Care Initiative (CCI).

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the Health Care Options (HCO) program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care institutional services, In-Home Supportive Services, Community-Based Adult Services, Multi-Purpose Senior Services Program, and other Home and Community-Based Services from fee-for-service into managed care health plans. Notices and packets will be mailed to beneficiaries.

In addition, to ensure a seamless enrollment selection process for beneficiaries impacted by the upcoming CCI programs, costs have been included for a beneficiary-centric specialized call center and specialized informing materials. The beneficiaries covered under this project will have a dedicated toll free number, which directs them to their own specialized team of CCI experts who will guide them through the enrollment process and be able to answer all the Medi-Cal and Medicare questions.

Reason for change from Prior Estimate:
CCI costs increased in FY 2014-15 due to the unexpected costs of mailings to additional beneficiaries, increased costs for translations of informing materials in Braille and audio formats.

Methodology:
1. Costs are negotiated through a contract amendment with a term through December 31, 2016. Costs include informing materials development and mailing, CCI telephone call center staffing and

HCO CCI - CAL MEDICONNECT AND MLTSS

OTHER ADMIN. POLICY CHANGE NUMBER: 59

equipment, and translations of informing materials into Braille and audio formats.

2. The FY 2014-15 and FY 2015-16 costs are below:

		FY 2014-15	FY 2015-16
Printing/Postage		$32,204,000	$8,103,000
Equipment/Non-Equipment		$2,435,000	$926,000
Staffing		$7,536,000	$7,107,000
	Total	**$42,175,000**	**$16,136,000**

3. Costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2014-15	**$42,175,000**	**$21,087,000**	**$21,088,000**

	TF	GF	FF
FY 2015-16	**$16,136,000**	**$8,068,000**	**$8,068,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	60
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1858

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$34,883,000	$37,646,000
STATE FUNDS	$17,179,300	$18,540,850
FEDERAL FUNDS	$17,703,700	$19,105,150

DESCRIPTION

Purpose:
This policy change estimates the total cost reimbursement of the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Cost reimbursements are direct costs incurred by the enrollment contractor while performing responsibilities under the contract that are in addition to fixed operations costs.

Reason for change from Prior Estimate:
Rent and utilities at the contact center increased; as well as other changes including Medi-Cal publications' revisions and increased publication development costs.

Methodology:
1. Cost reimbursement categories in FY 2015-16 include a 10% contingency cost adjustment to accommodate unforeseen project increases including those resulting from legislative mandates.

2. Contract costs are shared between federal funds (FF) and general funds (GF).

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

FY 2014-15	TF	GF Title XIX (50%)	GF Title XXI (35%)	FF Title XIX (50%)	FF Title XXI (65%)
Postage	$16,117,000	$7,655,000	$282,000	$7,656,000	$524,000
Printing	$4,511,000	$2,142,000	$79,000	$2,143,000	$147,000
Other HCO Informing Materials	$4,161,000	$1,976,000	$73,000	$1,977,000	$135,000
Customer Assistance Telephone	$842,000	$400,000	$15,000	$400,000	$27,000
Development of New Informing Materials	$152,000	$72,000	$3,000	$72,000	$5,000
Translation Services	$133,000	$63,000	$2,000	$63,000	$5,000
Data Access	$174,000	$82,000	$3,000	$83,000	$6,000
Miscellaneous	$636,000	$302,000	$11,000	$302,000	$21,000
Special Training Sessions	$132,000	$62,000	$2,000	$63,000	$5,000
Personal Computers, Printers, Copy Machines	$77,000	$36,000	$1,000	$37,000	$3,000
Additional Systems Group Staff	$331,000	$157,000	$6,000	$157,000	$11,000
Travel and Per Diem	$115,000	$54,000	$2,000	$55,000	$4,000
Temporary Staff	$331,000	$157,000	$6,000	$157,000	$11,000
Medi-Cal Publications Mailings	$7,171,000	$3,406,000	$126,000	$3,406,000	$233,000
Total	**$34,883,000**	**$16,564,000**	**$611,000**	**$16,571,000**	**$1,137,000**

FY 2015-16	TF	GF Title XIX (50%)	GF Title XXI (35%)	FF Title XIX (50%)	FF Title XXI (65%)
Postage	$17,728,000	$8,421,000	$310,000	$8,421,000	$576,000
Printing	$4,961,000	$2,356,000	$87,000	$2,357,000	$161,000
Other HCO Informing Materials	$4,577,000	$2,174,000	$80,000	$2,174,000	$149,000
Customer Assistance Telephone	$926,000	$440,000	$16,000	$440,000	$30,000
Development of New Informing Materials	$166,000	$79,000	$3,000	$79,000	$5,000
Translation Services	$146,000	$69,000	$2,000	$70,000	$5,000
Data Access	$191,000	$90,000	$4,000	$91,000	$6,000
Miscellaneous	$699,000	$332,000	$12,000	$332,000	$23,000
Special Training Sessions	$145,000	$69,000	$2,000	$69,000	$5,000
Personal Computers, Printers, Copy Machines	$84,000	$40,000	$1,000	$40,000	$3,000
Additional Systems Group Staff	$363,000	$172,000	$6,000	$173,000	$12,000

HCO COST REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 60

FY 2015-16	TF	GF Title XIX (50%)	GF Title XXI (35%)	FF Title XIX (50%)	FF Title XXI (65%)
Travel and Per Diem	$126,000	$60,000	$2,000	$60,000	$4,000
Temporary Staff	$363,000	$172,000	$6,000	$173,000	$12,000
Medi-Cal Publications Mailings	$7,171,000	$3,406,000	$126,000	$3,406,000	$233,000
Total	**$37,646,000**	**$17,880,000**	**$657,000**	**$17,885,000**	**$1,224,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ACA EXPRESS LANE ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	61
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1863

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$16,153,000	$0
STATE FUNDS	$8,076,500	$0
FEDERAL FUNDS	$8,076,500	$0

DESCRIPTION

Purpose:
This policy change estimates the costs for additional resources for the Health Care Options (HCO) program to provide information and enrollment assistance to beneficiaries for Express Lane Medi-Cal enrollment.

Authority:
SBx1 1 (Chapter 4, Statutes of 2013)
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

The Centers for Medicare and Medicaid Services (CMS) has provided several options to facilitate enrollment into the Medicaid programs. These options are designed to alleviate the influx of applications under the Affordable Care Act by providing Medicaid eligibility to certain groups without conducting a separate Medicaid eligibility determination. SBx1 1 requires the Department to seek the necessary federal waivers to implement two of these options. In December 2013, CMS approved the Department's waiver to provide Express Lane Enrollment into Medi-Cal. On February 2, 2014, the Department began mailing special informing notices to over 600,000 CalFresh eligible adults and children in County Organized Health Care System (COHS) and non-COHS managed care counties. In October of 2014, the Department will begin a second CalFresh Express Lane II mailing of special informing notices to beneficiaries to re-inform them of their health care options.

MAXIMUS, Inc. will continue to provide special telephone call center enrollment assistance to Express Lane beneficiaries through March 30, 2015.

Reason for change from Prior Estimate:
Costs were added to mailing additional informing materials and for the enrollment contractor's telephone call center to provide enrollment assistance to Express Lane II beneficiaries.

HCO ACA EXPRESS LANE ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 61

Methodology:

1. Costs are negotiated per agent costs and special informing materials rates through a contract amendment with a term through March 30, 2015.

	FY 2014-15
Express Lane	$9,889,000
Express Lane II	$6,264,000
Total	**$16,153,000**

2. Contract costs are shared between federal funds (FF) and general funds (GF).

	TF	GF	FF
FY 2014-15	**$16,153,000**	**$8,076,000**	**$8,077,000**

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	62
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1857

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$13,373,000	$13,715,000
STATE FUNDS	$6,586,150	$6,754,600
FEDERAL FUNDS	$6,786,850	$6,960,400

DESCRIPTION

Purpose:
This policy change estimates the hourly reimbursement costs of the Health Care Options (HCO) program for the contractor's Enrollment Services Representatives (ESRs).

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for HCO since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

An important goal of the HCO program is to provide every Medi-Cal applicant/ beneficiary, who shall be required or is eligible to enroll in a medical and/or dental plan under the Medi-Cal Managed Care program, with the opportunity to receive a face-to-face presentation describing that individual's rights and enrollment choices as well as a fundamental introduction to the managed health care delivery system. The primary objective of the HCO presentation is to educate applicants/beneficiaries to make an informed plan choice. An effective educational program ultimately increases the number of potential eligible enrollees who choose a plan prior to or during the informing process, thereby avoiding auto-assignment (default assignment) to a plan. This program is conducted by the enrollment contractor with the use of ESRs in county offices statewide.

AB 1467 (Chapter 23, Statutes of 2012) authorizes the expansion of managed care into rural areas that are currently fee-for-service and will provide beneficiaries care through an organized delivery system. The expansion requires an increase from 130 to 155 of enrollment contractor ESRs and requires additional funds to be added to the contract authority for initial transition and on-going mailings and enrollment services assistance.

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

HCO ESR HOURLY REIMBURSEMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 62

Methodology:

1. The hourly reimbursement costs are fixed price hourly rates for full-time equivalent ESR staff at ESR sites statewide.

2. Costs are shared between federal funds (FF) and general funds (GF).
   - 50/50 for Administration, and
   - 65/35 for Medicaid Expansion Children's Health Insurance Program (MCHIP)

3. The estimated costs for FY 2014-15 are based on 155 ESRs for a total cost of $13,373,000.

4. The estimated costs for FY 2015-16 are based on 155 ESRs for a total cost of $13,715,000.

FY 2014-15	**TF**	**GF**	**FF**
Title XIX (50% FF / 50% GF)	$12,704,000	$6,352,000	$6,352,000
Title XXI (65% FF / 35% GF)	$669,000	$234,000	$435,000
Total	**$13,373,000**	**$6,586,000**	**$6,787,000**

FY 2015-16	**TF**	**GF**	**FF**
Title XIX (50% FF / 50% GF)	$13,029,000	$6,514,000	$6,515,000
Title XXI (65% FF / 35% GF)	$686,000	$240,000	$446,000
Total	**$13,715,000**	**$6,754,000**	**$6,961,000**

Funding:

FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO - ACA ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	63
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1864

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$12,633,000	$10,275,000
STATE FUNDS	$6,221,700	$5,060,400
FEDERAL FUNDS	$6,411,300	$5,214,600

DESCRIPTION

Purpose:
This policy change estimates the costs for additional resources for the Health Care Options (HCO) program to provide informing and enrollment assistance to beneficiaries eligible for Medi-Cal from the implementation of the Affordable Care Act (ACA).

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Effective January 1, 2014, the ACA establishes a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income of 133% of the federal poverty level for pregnant women, children up to age 19, and parent/caretaker relatives by which these additional populations will potentially become eligible for Medi-Cal. The enrollment contractor will require additional resources in its telephone call center to adequately and effectively provide informing and enrollment assistance functions to the increasing numbers of Medi-Cal beneficiaries resulting from the ACA.

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

Methodology:
1. Costs are negotiated per agent/person costs through a contract amendment.

2. Contract costs are shared between federal funds (FF) and general funds (GF).

HCO - ACA ENROLLMENT CONTRACTOR COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 63

	FY 2014-15	FY 2015-16
Telephone Call Center Enrollment Operations	$10,884,000	$7,871,000
Training	$227,000	$0
System Group Staff	$1,522,000	$2,404,000
Total	**$12,633,000**	**$10,275,000**

FY 2014-15	TF	GF	FF
Title XIX (50% FF / 50% GF)	$12,001,000	$6,000,000	$6,001,000
Title XXI (65% FF / 35% GF)	$632,000	$221,000	$411,000
Total	**$12,633,000**	**$6,221,000**	**$6,412,000**

FY 2015-16	TF	GF	FF
Title XIX (50% FF / 50% GF)	$9,761,000	$4,880,000	$4,881,000
Title XXI (65% FF / 35% GF)	$514,000	$180,000	$334,000
Total	**$10,275,000**	**$5,060,000**	**$5,215,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER:	64
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1862

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$3,772,000	$727,000
STATE FUNDS	$1,886,000	$363,500
FEDERAL FUNDS	$1,886,000	$363,500

DESCRIPTION

Purpose:
This policy change estimates the informing and enrollment costs for Seniors and Persons with Disabilities (SPD) transitioning into to managed care rural counties.

Authority:
AB 1467 (Chapter 23, Statutes of 2012)
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the Health Care Options program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care (GMC), San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

Managed care is currently in 30 counties. AB 1467 expands managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

The first phase of expansion will be implemented on September 1, 2013 in the eight County Organized Health System (COHS) counties, and will be followed by the remaining 20 counties (Two-Plan, GMC-Plan and Single-Plan models) on November 1, 2013. Informing material mailings to beneficiaries (special notices, frequently asked questions, and special packets) started for COHS counties in July 2013. The 20 Two-Plan, GMC-Plan, and Single-Plan model counties will require newly established enrollment presentation sites and the hiring, training and equipment costs associated with staffing these county enrollment sites. County site staffing started in 2013.

SPDs will transition from fee-for-service to managed care in the rural counties on December 1, 2014. The enrollment contractor will incur additional costs to provide call center support and special informing and enrollment assistance to this SPD transition population through December 31, 2015.

HCO- SPD TRANSITION TO MANAGED CARE RURAL COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER: 64

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

Methodology:
1. Costs are negotiated per agent costs through a contract amendment.

2. Costs are shared between federal funds (FF) and general funds (GF).

	FY 2014-15	FY 2015-16
Packets	$364,000	$0
FAQ Booklets	$156,000	$0
Notices	$97,000	$0
COHS Mailings	$53,000	$0
Translation	$9,000	$0
Systems Group Staff	$37,000	$0
QA Analyst Staff	$81,000	$21,000
Customer Service Representatives	$2,825,000	$706,000
Service Costs	$150,000	$0
Total	**$3,772,000**	**$727,000**

	TF	GF	FF
FY 2014-15	**$3,772,000**	**$1,886,000**	**$1,886,000**

	TF	GF	FF
FY 2015-16	**$727,000**	**$363,000**	**$364,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO LIHP ENROLLMENT

OTHER ADMIN. POLICY CHANGE NUMBER:	65
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1861

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$1,426,000	$0
STATE FUNDS	$713,000	$0
FEDERAL FUNDS	$713,000	$0

DESCRIPTION

Purpose:
This policy change estimates the Low Income Health Program (LIHP) project costs for the Health Care Options (HCO) program.

Authority:
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

California's Bridge to Reform Demonstration expands coverage to eligible low income adults through LIHP. The LIHP consists of the Medicaid Coverage Expansion, effective July 1, 2011, through December 31, 2013, at which time the majority of enrollees will become Medi-Cal eligible under Affordable Care Act. These individuals will transition into Medi-Cal managed care beginning January 1, 2014.

The Department has developed beneficiary notices informing beneficiaries of the transition process. Beginning November 1, 2013, approximately 500,000 notices were mailed to beneficiaries. Due to the expanded scope of the project, there will be associated costs for the enrollment contractor to continue to provide telephone call center assistance through December 31, 2014.

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

Methodology:
1. Costs are negotiated per agent costs through a contract amendment with a term through December 31, 2014.

2. Costs are shared between federal funds (FF) and general funds (GF).

HCO LIHP ENROLLMENT

OTHER ADMIN. POLICY CHANGE NUMBER: 65

	TF	GF	FF
FY 2014-15	**$1,426,000**	**$713,000**	**$713,000**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

HCO PPDs - COST SAVINGS

OTHER ADMIN. POLICY CHANGE NUMBER:	66
IMPLEMENTATION DATE:	7/2014
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1859

	FY 2014-15	FY 2015-16
TOTAL FUNDS	-$2,083,000	-$2,996,000
STATE FUNDS	-$1,025,900	-$1,475,500
FEDERAL FUNDS	-$1,057,100	-$1,520,500

DESCRIPTION

Purpose:
This policy change estimates the cost savings for the Health Care Options (HCO) program from the Personalized Provider Directories (PPD) project.

Authority:
AB 203 (Chapter 188, Statutes of 2007)
HCO contract # 07-65829

Interdependent Policy Changes:
Not Applicable

Background:
MAXIMUS, Inc. has been the enrollment contractor for the HCO program since October 1, 1996. MAXIMUS, Inc. is responsible for enrolling Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care (GMC), San Benito and Imperial. MAXIMUS, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary.

HCO currently prints and mails health plan provider directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. AB 203 authorized the implementation of a PPD as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the PPDs were determined in consultation with health plans and stakeholders and resulted in smaller and more standardized user-friendly formats with up-to-date provider information. With the PPD's smaller directory, information to beneficiaries is streamlined and more easily understood. This has increased the numbers of beneficiaries who make a proactive health plan choice, in lieu of being defaulted into a health plan. The cost effective pilot project, which began in Los Angeles and Sacramento on February 27, 2009, is expected to be implemented statewide in June 2015.

Reason for change from Prior Estimate:
The PPD project is expected to be implemented statewide in June 2015, resulting in an increase in savings.

Methodology:
1. The current annual savings for Los Angeles and Sacramento is $2,000,000. The expected savings

HCO PPDs - COST SAVINGS

OTHER ADMIN. POLICY CHANGE NUMBER: 66

per month of statewide implementation is $83,000. Estimated savings for FY 2014-15 and FY 2015- 16 are shown below:

FY 2014-15: $2,000,000 + ($83,000 x 1 month) = **$2,083,000**

FY 2015-16: $2,000,000 + ($83,000 x 12 months) = **$2,996,000**

FY 2014-15	**TF**	**GF**	**FF**
Title XIX (50% FF / 50% GF)	($1,979,000)	($989,000)	($990,000)
Title XXI (65% FF / 35% GF)	($104,000)	($36,000)	($68,000)
Total	**($2,083,000)**	**($1,025,000)**	**($1,058,000)**

FY 2015-16	**TF**	**GF**	**FF**
Title XIX (50% FF / 50% GF)	($2,846,000)	($1,423,000)	($1,423,000)
Title XXI (65% FF / 35% GF)	($150,000)	($53,000)	($97,000)
Total	**($2,996,000)**	**($1,476,000)**	**($1,520,000)**

Funding:
FI 50% Title XIX / 50% GF (4260-101-0001/0890)
FI 65% Title XXI / 35% GF (4260-113-0001/0890)
***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	67
IMPLEMENTATION DATE:	4/1993
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	236

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$223,024,000	$230,866,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$223,024,000	$230,866,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for the county cost of administering two In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP), and IHSS Plus Option (IPO) program. Title XIX FFP is also provided to CDSS for the IHSS Case Management & Information Payrolling System (CMIPS) Legacy and CMIPS II.

Authority:
Interagency Agreement 03-75676

Interdependent Policy Changes:
Not Applicable

Background:
The IHSS programs, PCSP and IPO, enable eligible individuals to remain safely in their own homes as an alternative to out-of-home care. The PCSP and IPO program provide benefits that include domestic services, non-medical personal care services, and supportive services. The Medi-Cal program includes PCSP in its schedule of benefits.

Both the CMIPS Legacy and CMIPS II are currently used to authorize IHSS payments and provide CDSS and the counties with information such as wages, taxes, hours per case, cost per hour, caseload, and funding ratios.

Reason for Change from Prior Estimate:
Updated expenditure data was provided by CDSS.

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

PERSONAL CARE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 67

FY 2014-15	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$310,328,000	$155,164,000	$155,164,000
CMIPS II	$135,720,000	$67,860,000	$67,860,000
Total	$446,048,000	**$223,024,000**	$223,024,000

FY 2015-16	TF	DHCS FFP	CDSS GF/ County Match
EW Time & Health Related	$378,408,000	$189,204,000	$189,204,000
CMIPS II	$83,324,000	$41,662,000	$41,662,000
Total	$461,732,000	**$230,866,000**	$230,866,000

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

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER:	68
IMPLEMENTATION DATE:	7/1992
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	233

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$295,794,000	$251,727,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$295,794,000	$251,727,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for certain health-related activities provided by county social workers.

This policy change reflects the 100% FFP provided to CDSS.

Authority:
Interagency Agreements:

CWS	01-15931
CWS/CMS	06-55834
CSBG/APS	01-15931

Interdependent Policy Changes:
Not Applicable

Background:
The health-related services involve helping Medi-Cal eligibles to access covered medical services or maintain current treatment levels in these program areas: 1) Child Welfare Services (CWS); 2) Child Welfare Services/Case Management System (CWS/CMS); 3) County Services Block Grant (CSBG); and 4) Adult Protective Services (APS).

Reason for Change from Prior Estimate:
Updated expenditure data received from CDSS.

HEALTH-RELATED ACTIVITIES - CDSS

OTHER ADMIN. POLICY CHANGE NUMBER: 68

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

FY 2014-15	TF	DHCS FFP	CDSS GF/ County Match
CWS	$321,544,000	$160,772,000	$160,772,000
CWS/CMS	$13,926,000	$6,963,000	$6,963,000
CSBG/APS	$256,118,000	$128,059,000	$128,059,000
TOTAL	$591,588,000	**$295,794,000**	$295,794,000

FY 2015-16	TF	DHCS FFP	CDSS GF/ County Match
CWS	$273,642,000	$136,821,000	$136,821,000
CWS/CMS	$11,852,000	$5,926,000	$5,926,000
CSBG/APS	$217,960,000	$108,980,000	$108,980,000
TOTAL	$503,454,000	**$251,727,000**	$251,727,000

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

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	69
IMPLEMENTATION DATE:	7/1997
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	243

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$41,517,000	$38,505,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$41,517,000	$38,505,000

DESCRIPTION

Purpose:
This policy change estimates the federal match for the California Department of Developmental Services (CDDS) administrative costs.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
CDDS administrative costs are comprised of Developmental Centers (DC) Medi-Cal Administration, Developmental Centers Medi-Cal Eligibility Contract, Home and Community Based Services (HCBS) Waiver Administration, Regional Centers (RC) Medicaid Administration, Regional Centers Nursing Home Reform (NHR), and Targeted Case Management (TCM).

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

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

Methodology:
1. CDDS provides the following cash estimates of its administrative cost components:

CDDS ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 69

FY 2014-15		DHCS FFP	CDDS GF	IA #
1	DC/SOSF Medi-Cal Admin.	$11,868,000	$11,868,000	03-75282/83
	DC/SOSF HIPAA*	$163,000	$0	03-75282/83
2	DC/SOSF MC Elig	$513,000	$513,000	01-15378
3	HCBS Waiver Admin.	$13,992,000	$13,992,000	01-15834
4	RC Medicaid Admin.	$8,749,000	$2,917,000	03-75734
5	NHR Admin.	$380,000	$380,000	03-75285
6	TCM HQ Admin.	$408,000	$408,000	03-75284
	TCM RC Admin.	$4,806,000	$4,806,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$41,517,000**	$34,883,000	

FY 2015-16		DHCS FFP	CDDS GF	IA #
1	DC/SOSF Medi-Cal Admin.	$6,116,000	$6,116,000	03-75282/83
	DC/SOSF HIPAA*	$163,000	$0	03-75282/83
2	DC/SOSF MC Elig	$547,000	$547,000	01-15378
3	HCBS Waiver Admin.	$15,098,000	$15,098,000	01-15834
4	RC Medicaid Admin.	$10,420,000	$3,473,000	03-75734
5	NHR Admin.	$512,000	$512,000	03-75285
6	TCM HQ Admin.	$330,000	$330,000	03-75284
	TCM RC Admin.	$4,681,000	$4,681,000	03-75284
	TCM HIPAA*	$638,000	$0	03-75284
	Total	**$38,505,000**	$30,758,000	

Funding:
100% Title XIX (4260-101-0890)
100% HIPAA FFP (4260-117-0890)*

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER:	70
IMPLEMENTATION DATE:	7/2002
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	256

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$24,796,000	$26,467,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$24,796,000	$26,467,000

DESCRIPTION

Purpose:
This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for administering various programs to Medi-Cal beneficiaries.

Authority:
Interagency Agreements (IA):

IHSS PCSP	03-75676
IHSS Health Related	01-15931
CWS/CMS for Medi-Cal	06-55834
IHSS Plus Option Sec. 1915(j)	09-86307
SAWS	04-35639
Medi-Cal State Hearings	10-87031 and 12-89543
Public Inquiry and Response	10-87023
Medicaid Disability Evaluation Services	10-87027
Licensing Related Activities for Mental Health Facilities	12-89443
IHSS CFCO	11-88407
CCI IA	13-90037

Interdependent Policy Changes:
Not Applicable

Background:
These costs cover the administration of the Personal Care Services Program (PCSP), the In-Home Supportive Services Plus Option (IPO) Section 1915(j), the Child Welfare Services/Case Management System (CWS/CMS), Statewide Automated Welfare System (SAWS), Community First Choice Option Program (CFCO), Coordinated Care Initiative (CCI) IA, and the California Community Transitions-Money Follows the Persons (CCT). The Department provides FFP to CDSS for services related to Medi-Cal beneficiaries. CDSS budgets the matching General Fund (GF).

Reason for Change from Prior Estimate:
The estimated costs have changed due to revised expenditure data provided by CDSS.

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

DEPARTMENT OF SOCIAL SERVICES ADMIN COST

OTHER ADMIN. POLICY CHANGE NUMBER: 70

FY 2014-15	TF	DHCS FFP	CDSS GF
IHSS PCSP	$8,050,000	$4,025,000	$4,025,000
IHSS Health Related	$62,000	$31,000	$31,000
CWS/CMS for Medi-Cal	$400,000	$200,000	$200,000
IHSS Plus Option Sec. 1915(j)	$3,280,000	$1,640,000	$1,640,000
SAWS	$470,000	$235,000	$235,000
Medi-Cal State Hearings	$17,626,000	$8,813,000	$8,813,000
Public Inquiry and Response	$294,000	$147,000	$147,000
Medicaid Disability Evaluation Services	$19,410,000	$9,705,000	$9,705,000
TOTAL	$49,592,000	**$24,796,000**	$24,796,000

FY 2015-16	TF	DHCS FFP	CDSS GF
IHSS PCSP	$14,026,000	$7,013,000	$7,013,000
IHSS Health Related	$24,000	$12,000	$12,000
CWS/CMS for Medi-Cal	$360,000	$180,000	$180,000
IHSS Plus Option Sec. 1915(j)	$3,968,000	$1,984,000	$1,984,000
SAWS	$430,000	$215,000	$215,000
Medi-Cal State Hearings	$11,704,000	$5,852,000	$5,852,000
Public Inquiry and Response	$298,000	$149,000	$149,000
Medicaid Disability Evaluation Services	$22,124,000	$11,062,000	$11,062,000
TOTAL	$52,934,000	**$26,467,000**	$26,467,000

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

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER:	71
IMPLEMENTATION DATE:	7/1992
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	234

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$27,503,000	$27,503,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$27,503,000	$27,503,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for the Maternal, Child and Adolescent Health (MCAH) programs.

Authority:
Interagency agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
The MCAH includes the following programs:

- Black Infant Health (BIH): Group intervention and case management services to pregnant and parenting African-American Medi-Cal eligible women in an effort to reduce the high death rate for African American infants.
- Comprehensive Perinatal Services Program (CPSP): Provides a wide range of services to Medi-Cal pregnant women, from conception through 60 days postpartum.
- Prenatal Care Guidance (PCG): Case management services for improved access to early obstetrical care for Medi-Cal eligible pregnant women.
- Scope of Work (SOW) Local Program Activities: Perinatal education, services, and referral provided to Medi-Cal eligible women.
- Adolescent Family Life Program (AFLP): Case management services for Medi-Cal eligible pregnant teens including education and prevention of subsequent pregnancies.

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

Methodology:
1. The Department claims Title XIX federal funds with Certified Public Expenditures (CPE) from local agencies.
2. Annual expenditures on the accrual basis are $24,655,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

MATERNAL AND CHILD HEALTH

OTHER ADMIN. POLICY CHANGE NUMBER: 71

3. The FY 2014-15 budgeted amounts include $2,848,000 for FY 2012-13 and $9,862,000 for FY 2013-14, and $14,793,000 for FY2014-15.
   -
4. The FY 2015-16 budgeted amounts include $2,848,000 for FY 2013-14 and $9,862,000 for FY 2014-15, and $14,793,000 for FY2015-16.

5. The following estimates have been provided on a cash basis by CDPH.

(Dollars in Thousands)

FY 2014-15	**DHCS FFP**	**County Match**	**IA #**
BIH	$3,227	$2,752	07-65592
CPSP, PCG & SOW	$22,853	$16,298	
AFLP	$1,423	$1,316	
Total	**$27,503**	$20,366	

FY 2015-16	**DHCS FFP**	**County Match**	**IA #**
BIH	$3,227	$2,752	07-65592
CPSP, PCG & SOW	$22,853	$16,298	
AFLP	$1,423	$1,316	
Total	**$27,503**	$20,366	

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

HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE

OTHER ADMIN. POLICY CHANGE NUMBER:	72
IMPLEMENTATION DATE:	7/1999
ANALYST:	Jason Moody
FISCAL REFERENCE NUMBER:	246

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$25,143,000	$25,143,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$25,143,000	$25,143,000

DESCRIPTION

Purpose:
This policy change budgets the Title XIX federal financial participation (FFP) for the Health Care Program for Children in Foster Care (HCPCFC). The Department of Social Services (CDSS) budgets the amounts for the non-federal share.

Authority:
Welfare & Institutions Code, Section 16501.3
AB 1111 (Chapter 147, Statutes of 1999)
SB 1013 (Chapter 35, Statutes of 2012)
Interagency Agreement (IA) 14-2002

Interdependent Policy Change:
Not Applicable

Background:
The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 was signed into law on October 7, 2008 to help:

- Connect and support relative caregivers,
- Improve the outcome for children in foster care,
- Provide for tribal foster care and adoption access, and
- Improve incentives for adoption.

On January 1, 2010, the Department, collaborating with the CDSS, implemented the new requirements to provide Health Oversight and Coordination.

The Budget Act of 1999 appropriated state General Funds (GF) to CDSS for the purpose of increasing the use of public health nurses in meeting the health care needs of children in foster care. AB 1111 established the enabling legislation for the HCPCFC. CDSS and the Department subsequently agreed to implement the HCPCFC through the existing Child Health and Disability Prevention (CHDP) program so counties can employ public health nurses to help foster care children access health-related services. The Department used the GF budgeted by CDSS and drew down FFP at the skilled professional medical staff enhanced rate of 75%. The aggregate funding passed through local CHDP programs to support the HCPCFC.

The 2011 Public Safety Realignment Initiative (Realignment) provides for a shift of responsibilities for the HCPCFC to local control under county welfare departments. Vehicle License Fund and Sales Tax revenues, which fund the state share of the program, will be transferred to the counties. To enable this

HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE

OTHER ADMIN. POLICY CHANGE NUMBER: 72

transition, SB 1013 provides continuing funding for the existing HCPCFC model for local CHDP programs to staff the HCPCFC with CHDP nursing staff through June 30, 2015. CDSS will redirect funds for this purpose from the newly established Local Revenue Fund of 2011. CDSS proposes the transition of the HCPCFC to full local control under the county welfare departments, effective July 1, 2015 contingent upon an appropriate mechanism to match enhanced FFP.

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

Methodology:
1. CDSS provides the annual Local Revenue Fund of $8,381,000.

(Dollars in Thousands)

	DHCS FFP	Local Revenue Fund
FY 2014-15	**$25,143**	$8,381

	DHCS FFP	Local Revenue Fund
FY 2015-16	**$25,143**	$8,381

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

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	73
IMPLEMENTATION DATE:	7/2007
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1192

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$10,701,000	$10,718,000
STATE FUNDS	$2,533,000	$2,533,000
FEDERAL FUNDS	$8,168,000	$8,185,000

DESCRIPTION

Purpose:
This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to services provided to Medi-Cal beneficiaries.

Authority:
Interagency Agreement (IA)

Interdependent Policy Changes:
Not Applicable

Background:
The Department entered into an IA with CDPH to allow for the provision of Title XIX federal funds as a reimbursement to CDPH. The non-federal matching funds will be budgeted by CDPH. This policy change is for the following programs support costs:

- Maternal, Child and Adolescent Health (MCAH)
- Office of AIDS
- Childhood Lead Prevention Program (CLPP)
- Center for Health Statistics and Informatics (CHSI)
- Licensing and Certification
- Skilled Nursing Facilities (SNF)

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability supplemental payment program (QASP) for nursing facilities (NF-Bs). The Department will reimburse CDPH's Skilled Nursing Facilities administrative costs from this Special Fund. On July 31, 2015, in the absence of legislation, the QASP is scheduled to sunset. The Department is assuming continuation of the program beyond the July 31, 2015 sunset date.

On May 7, 2014, CMS instructed CDPH to submit Licensing and Certification Title XIX expenditure reports for Non-Long Term Care (NLTC) support costs. Effective January 2014, CMS will reimburse CDPH directly for NLTC support costs in the form of grant awards.

The Skilled Professional Medical Personnel cost are budgeted under the Maternal, Child and Adolescent Health program, and has an enhanced FMAP of 75%.

Reason for Change from Prior Estimate:
Licensing and Certification now excludes NLTC support costs.

FFP FOR DEPARTMENT OF PUBLIC HEALTH SUPPORT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 73

Methodology:

1. CDPH provides the General Fund match.

2. For Maternal, Child and Adolescent Health, the estimate includes an enhanced FMAP of 75% for Skilled Professional Medical Personnel costs.

3. CDPH provided the following estimates.

Cash Basis	DHCS	DHCS	CDPH	Other
FY 2014-15	FFP*	SP**	GF	Match
MCAH	$2,180,000		$1,902,000	
Office of AIDS	$373,000		$373,000	
CLPP	$1,512,000			$1,512,000
CHSI	$718,000			$718,000
Licensing and Certification	$852,000			$852,000
Skilled Nursing Facilities	$2,533,000	$2,533,000		
Total	**$8,168,000**	**$2,533,000**	$2,275,000	$3,082,000

FY 2015-16	DHCS	DHCS	CDPH	Other
	FFP*	SP**	GF	Match
MCAH	$2,180,000		$1,902,000	
Office of AIDS	$390,000		$390,000	
CLPP	$1,512,000			$1,512,000
CHSI	$718,000			$718,000
Licensing and Certification	$852,000			$852,000
Skilled Nursing Facilities	$2,533,000	$2,533,000		
Total	**$8,185,000**	**$2,533,000**	$2,292,000	$3,082,000

Funding:

100% Title XIX FFP (4260-101-0890)*
SNF Quality & Accountability (non-GF) (4260-605-3167)**

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	74
IMPLEMENTATION DATE:	7/1997
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	239

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$7,400,000	$5,200,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$7,400,000	$5,200,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for administrative costs associated with Childhood Lead Poisoning Prevention (CLPP) Program case management services.

Authority:
Interagency Agreement (IA) #07-65689

Interdependent Policy Changes:
Not Applicable

Background:
The CLPP Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments which provide the case management services. Some of these services are provided to Medi-Cal eligibles. To the extent that local governments have administrative costs associated with case management services to Medi-Cal eligibles, federal matching funds can be claimed. The federal match is provided to CDPH through an Interagency Agreement.

Reason for Change from Prior Estimate:
The changes are due to:
- Contract approval delay
- Local jurisdictions invoicing delays to CDPH

Methodology:
1. Annual expenditures on the accrual basis are $8,400,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.

2. The estimates are provided by CDPH on a cash basis.

(In Thousands)

FY 2014-15	**DHCS FFP**	**CDPH CLPP Fee Funds**
Administrative Costs	**$7,400**	$7,400

FY 2015-16	**DHCS FFP**	**CDPH CLPP Fee Funds**
Administrative Costs	**$5,200**	$5,200

CLPP CASE MANAGEMENT SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER: 74

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

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	75
IMPLEMENTATION DATE:	7/1984
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	253

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$3,463,000	$3,297,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,463,000	$3,297,000

DESCRIPTION

Purpose:
This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Aging (CDA) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP). Enhanced federal funding is also provided to CDA for administrative costs related to services provided to eligibles utilizing Aging and Disability Resource Centers (ADRC).

Authority:
Interagency Agreements:
CBAS 03-76137
MSSP 01-15976

Interdependent Policy Changes:
Not Applicable

Background:
The CDA coordinates with the Department to obtain FFP for the administrative costs for services related to Medi-Cal beneficiaries. CDA budgets the matching General Fund (GF).

Reason for Change from Prior Estimate:
Estimated projections were updated by CDA.

DEPARTMENT OF AGING ADMINISTRATIVE COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 75

Methodology:
The estimates below, on a cash basis, were provided by CDA.

(Dollars in Thousands)

	FY 2014-15		FY 2015-16	
CBAS Support	**CDA GF**	**FFP**	**CDA GF**	**FFP**
FY 2013-14 DOS	$4	$4		
FY 2014-15 DOS	$1,527	$1,768	$47	$55
FY 2015-16 DOS			$1,527	$1,769
Total CBAS	$1,531	$1,772	$1,574	$1,824
MSSP Support				
FY 2013-14 DOS	$3	$3		
FY 2014-15 DOS	$1,230	$1,421	$38	$44
FY 2015-16 DOS			$1,232	$1,421
Total MSSP	$1,233	$1,424	$1,270	$1,465
ADRC Support*				
FY 2014-15 DOS		$267		$8
FY 2015-16 DOS				
Grand Total	$2,764	**$3,463**	$2,844	**$3,297**

Funding:
100% Title XIX (4260-101-0890)
100% MFP Federal Grant (4260-106-0890)*

CHHS AGENCY HIPAA FUNDING

OTHER ADMIN. POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	7/2001
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	257

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$1,206,000	$1,215,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,206,000	$1,215,000

DESCRIPTION

Purpose:
This policy change estimates and reimburses the California Health and Human Services (CHHS) Agency the federal funds for qualifying Health Insurance Portability and Accountability Act (HIPAA) activities related to Medi-Cal.

Authority:
Interagency Agreement (IA) 14-90234

Interdependent Policy Changes:
Not Applicable

Background:
A HIPAA office has been established at the CHHS Agency to coordinate implementation and set policy requirements for departments utilizing Title XIX funding. This funding supports State positions and contracted staff to assist in the implementation of HIPAA rules at the Agency level. These staff provide oversight and subject matter expertise in HIPAA rules.

Reason for Change from Prior Estimate:
A new IA (14-90234) replaces IA 11-88125, which expired on 6/30/2014. Estimated costs are based on contract amounts stated in the new IA.

Methodology:
1. The CHHS Agency prioritizes HIPAA projects so that the most critical projects are implemented first.

Cash Basis	DHCS FF	CHHS GF
FY 2014-15	**$1,206,000**	$1,206,000
FY 2015-16	**$1,215,000**	$1,215,000

Funding:
100% HIPAA (4260-117-0890)

TOBACCO QUITLINE ADMINISTRATIVE SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	77
IMPLEMENTATION DATE:	1/2014
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	1680

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$1,000,000	$1,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,000,000	$1,000,000

DESCRIPTION

Purpose:
This policy change estimates the Title XIX federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for administrative costs related to Tobacco Quitline Services provided to Medi-Cal beneficiaries.

Authority:
Interagency Agreement (IA) 13-90417

Interdependent Policy Change:
Not Applicable

Background:
The Tobacco Quitline is California Smokers' Helpline, operated by the University of California, San Diego. Tobacco Quitline provides a free telephone-based counseling program to provide advice, education, and support to callers who currently smoke or have recently quit smoking.

The Department executed an IA with CDPH to enable the State to receive 50% FFP for Tobacco Quitline Services administrative costs beginning July 1, 2013.

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

Methodology:
1. The program's effective date is July 1, 2013.

2. Total Quitline services administration costs are $4 million annually.

3. Assume 50% of callers are Medi-Cal beneficiaries.

4. The State receives 50% FFP. The estimated annual FFP on an accrual basis is $1,000,000.

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

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER:	78
IMPLEMENTATION DATE:	12/1988
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	232

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$956,000	$956,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$956,000	$956,000

DESCRIPTION

Purpose:
This policy change estimates the Title XIX federal funding provided to the California Department of Veterans Affairs (CDVA) for distribution to County Veteran Service Officers (CVSO) for identifying veterans eligible for Veterans Affairs (VA) benefits.

Authority:
AB 1807(Chapter 1424, Statutes of 1987)
California Military & Veterans Code 972.5
Interagency Agreement 14-90187

Interdependent Policy Changes:
Not Applicable

Background:
Assembly Bill (AB) 1807 permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the California Department of Veterans Affairs (CDVA). County Veteran Services officers help identify additional veterans' benefits and refers the veteran to utilize those services instead of Medi-Cal. This process avoids costs for the Medi-Cal program. The contract amounts for FY 2014-15 and FY 2015-16 is estimated to be $956,000. The non-federal match is budgeted at CDVA.

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

Methodology:
(Dollars in Thousands)

Cash Basis

FY 2014-15	TF	CDVA GF	DHCS FF
Administrative	$436	$218	$218
Workload Units	$1,476	$738	$738
Total	$1,912	$956	**$956**

FY 2015-16	TF	CDVA GF	DHCS FF
Administrative	$436	$218	$218
Workload Units	$1,476	$738	$738
Total	$1,912	$956	**$956**

VETERANS BENEFITS

OTHER ADMIN. POLICY CHANGE NUMBER: 78

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

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER:	79
IMPLEMENTATION DATE:	7/2003
ANALYST:	Joel Singh
FISCAL REFERENCE NUMBER:	261

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$946,000	$946,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$946,000	$946,000

DESCRIPTION

Purpose:
This policy change estimates the federal financial participation (FFP) provided to the California Department of Public Health (CDPH) for the Information and Education (I&E) program to establish and implement clinical linkages to the Family Planning, Access, Care and Treatment (Family PACT) program.

Authority:
Interagency Agreement 07-65592
AB 1762 (Chapter 230, Statutes of 2003)

Interdependent Policy Changes:
Not Applicable

Background:
AB 1762 authorized the Department to require contractors and grantees under the Office of Family Planning (OFP) and the I&E program to establish and implement clinical linkages to the Family PACT program. This linkage includes planning and development of a referral process for program participants to ensure access to family planning and other reproductive health care services, including technical assistance, training, and an evaluation component for grantees.

CDPH budgets the I&E program under the Maternal, Child and Adolescent Health Division.

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

Methodology:
1. CDPH budgets the non-federal matching funds.

2. CDPH provides the estimated costs on a cash basis.

FY 2014-15	TF	CDPH GF	DHCS FF
FY 2013-14	$568,000	$284,000	$284,000
FY 2014-15	$1,324,000	$662,000	$662,000
	$1,892,000	$946,000	**$946,000**

CDPH I&E PROGRAM AND EVALUATION

OTHER ADMIN. POLICY CHANGE NUMBER: 79

FY 2015-16	TF	CDPH GF	DHCS FF
FY 2013-14	$568,000	$284,000	$284,000
FY 2014-15	$1,324,000	$662,000	$662,000
	$1,892,000	$946,000	**$946,000**

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

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER:	80
IMPLEMENTATION DATE:	7/2001
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	249

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$935,000	$913,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$935,000	$913,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Children and Families Commission (CCFC) for providing “Welcome Kits” to parents of Medi-Cal eligible newborns.

Authority:
Interagency Agreement (IA) #03-76097

Interdependent Policy Changes:
Not Applicable

Background:
In November 2001, CCFC and the Department entered into an IA to allow the Department to claim Title XIX federal financial participation (FFP) for the "Welcome Kits" distributed to parents of Medi-Cal eligible newborns by the CCFC (Proposition 10).

Reason for Change from Prior Estimate:
The costs for the “Welcome Kits” has decreased.

Methodology:

1. CCFC will distribute an estimated 370,000 kits in FY 2014-15 and FY 2015-16, of these 46% of the kits are expected to be distributed to Medi-Cal eligible newborns.

   370,000 kits x 46% = 170,200 Medi-Cal kits

2. Approximately 51% of the kits distributed will be basic kits and 49% will be custom kits.

   170,200 Medi-Cal kits x 51% = 86,802 basic kits
   170,200 Medi-Cal kits x 49% = 83,398 custom kits

3. As of July 1, 2014, the basic kit costs $10.68 and the customized kit, which contains an additional item specific to the county of birth, costs $10.77.

4. For the FY 2014-15 expenditures, $501,000 of the costs are from the last quarter of FY 2013-14 and $1,368,750 of the costs are from the first three quarters of FY 2014-15.

5. For the FY 2015-16 expenditures, $456,250 of the costs are from the last quarter of FY 2014-15 and $1,368,750 of the costs are from the first three quarters of FY 2015-16.

KIT FOR NEW PARENTS

OTHER ADMIN. POLICY CHANGE NUMBER: 80

Annual Cost (Accrual Basis)	
86,802 basic kits x $10.68	$ 927,000
83,398 custom kits x $10.77	$ 898,000
Total FY 2014-15 Cost	**$1,825,000**

Cash Basis	**FY 2014-15**	**FY 2015-16**
FY 2013-14	$ 501,000	$0
FY 2014-15	$1,368,750	$ 456,250
FY 2015-16	$0	$1,368,750
Total:	$1,869,750	$1,825,000
FFP Total:	**$ 935,000**	**$ 913,000**

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER:	81
IMPLEMENTATION DATE:	3/2011
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1665

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$560,000	$983,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$560,000	$983,000

DESCRIPTION

Purpose:
This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR) for administrative costs related to the Inmate Eligibility Program.

Authority:
SB 1399 (Chapter 405, Statutes of 2010)
AB 396 (Chapter 394, Statutes of 2011)
Interagency Agreement #10-87275

Interdependent Policy Changes:
Not Applicable

Background:
AB 1628 authorizes the Department and CDCR to claim federal reimbursement for inpatient hospital services for adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties. As part of these provisions, CDCR is claiming federal financial participation (FFP) for their administrative costs to operate the Inmate Eligibility Program.

The federal funds provided to CDCR for the cost of inpatient services for inmates, deemed eligible for Medi-Cal or the LIHP, are included in the Medi-Cal Inpatient Hosp.Costs for Inmates and BTR–LIHP Inpatient Hospital Costs for CDCR Inmates policy changes respectively.

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% GF.

AB 396 authorizes the Department, counties, and the CDCR to claim 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 100 percent by CDCR or the county. Policy change CA 1 County Administration Base covers the county FFP for county inmates.

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

MEDI-CAL INPATIENT SERVICES FOR INMATES

OTHER ADMIN. POLICY CHANGE NUMBER: 81

Methodology:

1. Implementation of the Inmate Eligibility Program began April 1, 2011.

2. Reimbursements for CDCR's administrative costs began in March 2011.

3. The federal share of ongoing administrative costs is $560,000 in FY 2014-15 and $983,000 in FY 2015-16.

Funding:

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

MERIT SYSTEM SERVICES FOR COUNTIES

OTHER ADMIN. POLICY CHANGE NUMBER:	82
IMPLEMENTATION DATE:	7/2003
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	263

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$195,000	$195,000
STATE FUNDS	$97,500	$97,500
FEDERAL FUNDS	$97,500	$97,500

DESCRIPTION

Purpose:
This policy change estimates the cost for the interagency agreement (IA) with the California Department of Human Resources (CalHR).

Authority:
Interagency Agreement #12-89476

Interdependent Policy Changes:
Not Applicable

Background:
Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. Many counties do not have a civil service system that meet current state regulations. The Merit System Services Program was established under the State Personnel Board and is now administered by the CalHR to administer personnel services for the counties that do not have one. In addition, the CalHR reviews the merit systems in the remaining counties to ensure that they meet federal civil service requirements.

The Department reimburses the CalHR via an interagency agreement (IA) for Merit System Services. The agreement continues indefinitely, until terminated, or until there is a change in scope of work affecting the cost.

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

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

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

CDDS DENTAL SERVICES

OTHER ADMIN. POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	11/2011
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1631

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$84,000	$84,000
STATE FUNDS	$84,000	$84,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost related to processing the California Department of Developmental Services (CDDS) dental claims.

Authority:
Interagency Agreement 10-87244

Interdependent Policy Changes:
Not Applicable

Background:
The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal no longer covered most dental services for adults 21 years of age and older, CDDS entered into an interagency agreement with the Department to have the Medi-Cal dental Fiscal Intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of processing claims and benefits will be reimbursed by CDDS. Select adult optional dental services were reinstated May 1, 2014.

This policy change estimates the reimbursement of administration costs. The reimbursement of benefit costs is budgeted in the CDDS Dental Services policy change.

Reason for Change from Prior Estimate:
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. An update to the CD-MMIS began in November 2011.

2. The processing of claims began in January 2012 and payments to providers began in February 2012.

3. Assume the cost of processing claims is $84,000 annually.

4. All costs are reimbursed by CDDS.

Funding:
Reimbursement GF (4260-610-0995)

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2003
ANALYST:	Erickson Chow
FISCAL REFERENCE NUMBER:	1114

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$438,000	$382,000
STATE FUNDS	$219,000	$191,000
FEDERAL FUNDS	$219,000	$191,000

DESCRIPTION

Purpose:
This policy change estimates the costs related to courier services for Prison Industry Authority (PIA) eyewear.

Authority:
Interagency Agreement (IA) #13-90175

Interdependent Policy Changes:
Not Applicable

Background:
The California PIA fabricates eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an IA with PIA to reimburse them for one-half of the courier costs for the pick-up and delivery of orders to optical providers. The two-way courier service ensures that beneficiaries have continued access to and no disruption of optical services.

Reason for Change from Prior Estimate:
The new contract in FY 2013-14 resulted in a late submission for the third quarter invoice by PIA, so the payment for this quarter was not made until July 2014. Also, the new courier service contract has a lower rate per package which also lowered the cost of shipping.

Methodology:

1. The new contract is with State Delivery Service Inc. The cost per package rate is $1.375 plus a three percent fuel surcharge.

2. The annual cost of FY 2014-15 for 260,000 estimated shipped packages is:
   $1.375 x 1.03 x 260,000 = $368,000 TF

3. The annual cost of FY 2015-16 for 273,000 estimated shipped packages is:
   $1.375 x 1.03 x 273,000 = $387,000 TF

4. There is a one quarter lag for the payment of these services.

5. The new PIA contract in FY 2013-14 resulted in a late submission for the third quarter invoice. The payment for this quarter was not made until July 2014.

6. For FY 2014-15 costs, $162,000 are from FY 2013-14 services and $276,000 of the costs is from FY 2014-15 services.

PIA EYEWEAR COURIER SERVICE

OTHER ADMIN. POLICY CHANGE NUMBER: 84

7. For FY 2015-16 costs, $92,000 are from FY 2014-15 services and $290,000 of the costs is from FY 2015-16 services.

Cash Basis	**FY 2014-15**	**FY 2015-16**
FY 2013-14 Services	$162,000	$0
FY 2014-15 Services	$276,000	$ 92,000
FY 2015-16 Services	$0	$290,000
Budget Year Total	**$438,000**	**$382,000**

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

HCO ANNUAL OPEN ENROLLMENT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	7/2015
ANALYST:	Sandra Bannerman
FISCAL REFERENCE NUMBER:	1886

	FY 2014-15	FY 2015-16
TOTAL FUNDS	$0	$3,930,000
STATE FUNDS	$0	$1,965,000
FEDERAL FUNDS	$0	$1,965,000

DESCRIPTION

Purpose:
This policy change estimates the total costs for the Health Care Options Program (HCO) for the Annual Open Enrollment mailings.

Authority:
Proposed Legislation

Interdependent Policy Changes:
PC 196 Annual Open Enrollment

Background:
The Enrollment Contractor, Maximus, Inc., is responsible for administering the HCO Program through an enrollment broker contract to enroll Medi-Cal beneficiaries into managed care health plans within five Medi-Cal managed care health plan models including Two-Plan, Regional, Geographic Managed Care, San Benito and Imperial. Maximus, Inc. also enrolls beneficiaries into dental care plans in Sacramento County, where enrollment is mandatory, and Los Angeles County, where enrollment is voluntary. MAXIMUS, Inc. has been the Enrollment Contractor for the HCO Program since October 1, 1996.

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.

Maximus, Inc. will mail special notices each year to inform beneficiaries of the upcoming open enrollment period. These special notices will be mailed within a timeframe to ensure that beneficiaries receive the notices within thirty (30) days prior to the open enrollment period. Beneficiaries who wish to change plans may do so over the telephone or may request an HCO informing packet and complete and mail in the appropriate forms. The first open enrollment period is expected to begin on November 15, 2015 and continue through February 15, 2016.

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

HCO ANNUAL OPEN ENROLLMENT COSTS

OTHER ADMIN. POLICY CHANGE NUMBER: 86

Methodology:

1. Costs are not fixed price operations costs but will be reimbursed to Maximus, Inc. through a contract amendment.

2. Maximus, Inc. currently mails Annual Re-notification notices to beneficiaries each year to advise them of their right to make other health care choices. Costs reflect a savings with the discontinuance of these mailings which will offset the total costs for Annual Open Enrollment mailings.

(Dollars in thousands)

FY 2015-16

	TF	GF	FF
Printing and postage costs	$5,978	$2,989	$2,989
Printing and postage savings	($2,048)	($1,024)	($1,024)
	$3,930	**$1,965**	**$1,965**

Funding:

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

***This policy change is appropriated in the Fiscal Intermediary appropriation of the Management Summary.

FISCAL INTERMEDIARIES
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FISCAL INTERMEDIARY ESTIMATE

November 2014

FY 2014-15	**TOTAL**	**FEDERAL**	**STATE**
MEDICAL FISCAL INTERMEDIARY CONTRACT (a)	$244,100,000	$183,188,000	$60,912,000
DENTAL FISCAL INTERMEDIARY CONTRACT (b)	$104,392,000	$69,530,000	$34,862,000
STATE CONTROLLER/STATE TREASURER	$1,856,000	$1,147,000	$709,000
PROVIDER VERIFICATION FILE	$2,000	$1,000	$1,000
TOTAL MEDI-CAL COSTS	**$350,350,000**	**$253,866,000**	**$96,484,000**

Refugee expenditures of $137,895 are included in the Reimbursement line (4260-610-0995) in the Management Summary.

(a) Includes $1,300 TF ($450 GF) for Title XXI activities (4260-113-0001/0890), and $23,334,000 TF ($3,796,000 GF) for HIPAA (4260-117-0001/0890).

(b) Includes $200,000 TF ($70,000 GF) for Title XXI activities (4260-113-0001/0890), and $560,000 TF ($140,000 GF) for HIPAA (4260-117-0001/0890).

FISCAL INTERMEDIARY ESTIMATE

November 2014

FY 2015-16	**TOTAL**	**FEDERAL**	**STATE**
MEDICAL FISCAL INTERMEDIARY CONTRACT (a)	$234,298,000	$174,399,000	$59,899,000
DENTAL FISCAL INTERMEDIARY CONTRACT (b)	$109,325,000	$72,330,000	$36,995,000
STATE CONTROLLER/STATE TREASURER	$1,856,000	$1,148,000	$708,000
PROVIDER VERIFICATION FILE	$2,000	$1,000	$1,000
TOTAL MEDI-CAL COSTS	**$345,481,000**	**$247,878,000**	**$97,603,000**

Refugee expenditures of $136,047 are included in the Reimbursement line (4260-610-0995) in the Management Summary.

(a) Includes $10,496,000 TF ($2,677,000 GF) for HIPAA (4260-117-0001/0890).

(b) Includes $760,000 TF ($190,000 GF) for HIPAA (4260-117-0001/0890).

Fiscal Year 2014-15 Comparison

	2014-15 Appropriation		Nov 2014 Estimate		Difference btwn. Nov 14 & Appr.	
	Total Funds	State Funds	Total Funds	State Funds	Total Funds	State Funds
Total Medical Fiscal Intermediary	$255,355,000	$62,208,000	$244,100,000	$60,912,000	($11,255,000)	($1,296,000)
Total Dental Fiscal Intermediary	$99,835,000	$31,728,000	$104,392,000	$34,862,000	$4,557,000	$3,134,000
Total Miscellaneous Expenditures	$18,568,000	$709,000	$1,858,000	$710,000	($16,710,000)	$1,000
GRAND TOTAL	**$373,758,000**	**$94,645,000**	**$350,350,000**	**$96,484,000**	**($23,408,000)**	**$1,839,000**

Fiscal Year 2015-16 Comparison

	Nov 2014 Estimate		Difference btwn. CY and BY	
	Total Funds	State Funds	Total Funds	State Funds
Total Medical Fiscal Intermediary	$234,298,000	$59,899,000	($9,802,000)	($1,013,000)
Total Dental Fiscal Intermediary	$109,325,000	$36,995,000	$4,933,000	$2,133,000
Total Miscellaneous Expenditures	$1,858,000	$709,000	$0	($1,000)
GRAND TOTAL	**$345,481,000**	**$97,603,000**	**($4,869,000)**	**$1,119,000**

MEDICAL FISCAL INTERMEDIARY

MEDICAL FISCAL INTERMEDIARY

The Medi-Cal fiscal intermediary (FI) contract requires the FI to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles.

The FI contract was awarded to Xerox State Healthcare, LLC (Xerox), on December 8, 2009. The contract effective date was May 3, 2010, which began the Takeover phase. During this phase HP Enterprise Services, LLC (HP) continued operations and work on Turnover activities through to the successful Assumption of Operations (AOO) by Xerox on October 3, 2011.

The main cost components of the FI contract are as follows:

Operations – Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Medicaid Management Information System (CA-MMIS). These cost categories consist of General and Online Drug Adjudicated Claim Lines (ACLs), Drug Use Review (DUR) inquiries, Encounter Claim Lines, California Eligibility Verification and Management Systems (CA-EVS/CMS) processing, Medicare Drug Discount Program, Treatment Authorization Requests and the Telephone Services Center (TSC). The FI has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

Hourly Reimbursement – Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG) and Field Office Automation Group (FOAG) Pharmacists. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the CA-MMIS. FOAG Pharmacists administer processes and review drug Treatment Authorization Requests (TAR) in accordance with the Department's criteria, guidelines and policy. They provide consultation services to Contractor staff consultants, physicians, nurses, and Field Office personnel. FOAG Pharmacists independently evaluate and adjudicate TARs and maintain currency with continuously evolving healthcare practices, equipment and technology.

Cost Reimbursement – Various costs incurred by the Contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of the contract. Any of the following costs may be cost reimbursed under the contract:

1) Postage,
2) Parcel services and common carriers,
3) Personal computers, monitors, printers, related equipment, and software,
4) Printing,
5) Telephone toll charges,
6) Audio text equipment,
7) Data center access,
8) Special training sessions,
9) Facilities improvement and modifications,
10) Audits and research,
11) Sales tax,
12) Change orders,
13) The Medi-Cal Print and Distribution Center,
14) DUR and Eligibility Verification Telecommunications,
15) FOAG equipment and furniture, and

16) Independent Verification & Validation and Consultant Contracts

Costs under these categories consist of direct costs, or subsets thereof, which can be specifically identified with the particular cost objective.

Other Estimated Costs – Costs under this category consists of payment to the Contractor for other contract services, such as Beneficiary ID Cards, cost containment, fixed price hourly billable Systems Group projects such as PAVE and ICD-10, etc.

Change Orders – A Change Order (CO) is a documentable increase of effort identified as having a direct relation to the administration of the contract that is above the volume of the required work within the scope, and above the normal fixed-price of the contract. Costs under this category are due to the Department altering the work required, or reallocating functions within the general scope of the contract, that the Department in its sole discretion may do any time during the life of the Contract. When the Department alters the work and causes a documentable increase or decrease in the required work effort of the Contractor, a CO is warranted. As the total number of active COs increase, the annual CO expenditures also increase. Modifications to the Contractor's responsibilities resulting in COs, are billed separately from the contract Operations.

Enhancements – Enhancements are work activities that have been identified as a new feature or modification of an existing feature requiring a change to the automated system. The Contractor is paid for the Design, Development and Implementation (DDI) of each Enhancement. Unlike regular operations activities, Enhancements are not always part of the FI Budget. Costs in this category may be due to new laws or regulations such as HIPAA, ICD-10, ACA, etc., that alter the bid requirements, changes in hardware or software requirements, technical and/or schedule delays that cause a shift in milestone payment dates, etc.

Optional Contractual Services – Optional Contractual Services (OCS) are Contractor-proposed methods of providing services, functions, and procedures above contract requirements to improve the CA-MMIS performance. OCSs can apply to the Legacy System or to the Replacement System. Unlike regular operations activities, OCSs are not always part of the FI Budget. Costs in this category are due to the Contractor proposing an OCS and the Department approving the OCS.

System Replacement – System Replacement (SR) constitutes the contractual responsibilities required for the Contractor to replace the existing CA-MMIS, as defined by the FI Contract. The Department plans to replace the 30-year old CA-MMIS, which ensures timely and accurate claims processing for Medi-Cal providers. The Department continues to update the current system to incorporate technological advances. The updates address new business and legislative requirements. Because of the updates, CA-MMIS is extremely complex, difficult to maintain, and near the end of its useful life cycle. The Department scheduled the CA-MMIS SR Project in four phases. The Contractor is paid for the Design, Development and Implementation (DDI) of the SR Project at the completion of each phase. Planning work on the system began in January 2012. The Department plans to implement Phase I in February 2015. Phase II planning began in February 2013, with an expected implementation date of July 2015. The Department scheduled Phase III to begin in FY 2013-14. The Department scheduled the final phase of planning to begin in FY 2014-15.

Medical Fiscal Intermediary Summary
November 2014

FY 2014-15

	Total Funds	State Funds
Operations	$95,604,498	$31,222,671
Hourly Reimbursement	$18,906,048	$4,559,652
Cost Reimbursement	$31,214,696	$8,902,979
Other Estimated Costs	$31,962,952	$5,922,382
Change Orders	$300,000	$150,000
Healthy Families (XXI)	$1,295	$453
Enhancements	$17,318,756	$2,074,787
Optional Contractual Services	$3,217,301	$321,730
System Replacements	$39,765,296	$6,255,081
Family PACT	$200,000	$100,000
Sub-Total	$238,490,842	$59,509,735
Sales Tax	$5,608,735	$1,402,184
TOTAL MEDICAL FI COSTS	**$244,099,577**	**$60,911,919**

FY 2015-16	**Total Funds**	**State Funds**
Operations	$92,756,341	$30,226,216
Hourly Reimbursement	$23,077,548	$5,435,667
Cost Reimbursement	$25,386,985	$7,770,259
Other Estimated Costs	$9,350,470	$2,662,618
Change Orders	$200,000	$100,000
Healthy Families (XXI)	$0	$0
Enhancements	$0	$0
System Replacements	$77,965,560	$12,263,983
Family PACT	$200,000	$100,000
Sub-Total	$228,936,904	$58,558,742
Sales Tax	$5,360,757	$1,340,189
TOTAL MEDICAL FI COSTS	**$234,297,661**	**$59,898,932**

MEDICAL FISCAL INTERMEDIARY ESTIMATE (DETAIL TABLE)
November 2014

FY 2014-15	TOTAL FUNDS
OPERATIONS	**$95,604,498**
General ACLs	$63,571,067
On-Line Pharmacy ACLs	$4,416,584
DUR	$310,000
Retrospective DUR	$75,807
Encounter Claim Lines	$1,614,000
CA-EVS/CMS Processing	$4,400,000
Medicare Drug Discount Program	$17,040
Treatment Authorization Requests	$9,000,000
Telephone Services Center	$12,200,000
HOURLY REIMBURSEMENT	**$18,906,048**
Systems Group	$18,354,600
Field Office Automation Group (FOAG)	$551,448
COST REIMBURSEMENT	**$31,214,696**
Postage	$2,843,550
Parcel Services & Common Carriers	$141,052
Equipment/Services	$6,362,523
P&D and PUBS	$3,487,496
Other Direct Costs	$764,780
Facilities Improve/Modif	$975,854
Audits & Research	$225,662
Change Orders	$132,000
Consultant Contracts	$8,347,442
Telecommunication	$2,165,721
Other Cost Reimburseable Items	$5,768,616
OTHER ESTIMATED COSTS	**$31,962,952**
Beneficiary ID Cards - BIC	$1,500,000
Health Access Program Cards	$270,000
Provision 11 & 57	$1,999,954
RAIS Medi-Cal	$1,500,000
RAIS MCO	$3,000,000
Cost Containment	$1,500,000
Fixed PrIce Billable SG	$22,192,998
CHANGE ORDERS	**$300,000**
Negotiated Change Orders	$300,000
Change Orders in Progress	$0
Unspecified Change Orders	$0

continued on next page

CY Medical FI Estimate (Detail Table), November 2014 Estimate
Continued from Page 8

FY 2014-15	TOTAL FUNDS
ENHANCEMENTS	**$17,318,756**
HIPAA 5010	$0
HIPAA ICD-10	$13,209,530
BRE	$4,109,226
OPTIONAL CONTRACTUAL SERVICES	**$3,217,301**
HITECH	$3,217,301
SYSTEM REPLACEMENTS	**$39,765,296**
HEALTHY FAMILIES (Title XXI only)	**$1,295**
FAMILY PACT	**$200,000**
SUBTOTAL	**$238,490,842**
SALES TAX 8%	$5,608,735
MEDICAL FI TOTAL FUND	**$244,099,577**

MEDICAL FISCAL INTERMEDIARY ESTIMATE (DETAIL TABLE
November 2014

FY 2015-16	TOTAL FUNDS
OPERATIONS	**$92,756,341**
General ACLs	$60,698,073
On-Line Pharmacy ACL s	$4,445,421
DUR	$320,000
Retrospective DUR	$75,807
Encounter Claim Lines	$1,000,000
CA-EVS/CMS Processing	$4,800,000
Medicare Drug Discount Program	$17,040
Treatment Authorization Requests	$9,200,000
Telephone Services Center	$12,200,000
HOURLY REIMBURSEMENT	**$23,077,548**
Systems Group	$22,526,100
Field Office Automation Group (FOAG)	$551,448
COST REIMBURSEMENT	**$25,386,985**
Postage	$2,680,763
Parcel Services & Common Carriers	$136,870
Equipment/Services	$6,251,617
P&D and PUBS	$3,120,122
Other Direct Costs	$650,439
Facilities Improve/Modif	$965,905
Audits & Research	$225,662
Change Orders	$132,000
Consultant Contracts	$7,162,802
Telecommunication	$2,289,022
Other Cost Reimburseable Items	$1,771,783
OTHER ESTIMATED COSTS	**$9,350,470**
Beneficiary ID Cards - BIC	$1,200,000
Health Access Program Cards	$270,000
Provision 11 & 57	$1,780,470
RAIS Medi-Cal	$1,500,000
RAIS MCO	$3,300,000
Cost Containment	$1,300,000
Fixed PrIce Billable SG	$0
CHANGE ORDERS	**$200,000**
Negotiated Change Orders	$200,000
Change Orders in Progress	$0
Unspecified Change Orders	$0

continued on next page

CY Medical FI Estimate (Detail Table), November 2014 Estimate
Continued from Page 10

FY 2015-16	TOTAL FUNDS
ENHANCEMENTS	**$0**
HIPAA 5010	$0
HIPAA ICD-10	$0
BRE	$0
SYSTEM REPLACEMENTS	**$77,965,560**
HEALTHY FAMILIES (TITLE XXI ONLY)	**$0**
FAMILY PACT	**$200,000**
SUBTOTAL	**$228,936,904**
SALES TAX 8%	$5,360,757
MEDICAL FI TOTAL FUND	**$234,297,661**

Assumptions

ACL Projections:

FY 2014-15

	General ACLs	Amount	Online-Drug ACLs	Amount
Total ACLs	205,790,076	63,572,348	36,063,827	$4,416,598
Less HFP	182,618	1,281	50,725	14
Total Medi-Cal ACLs	**$205,607,458**	**$63,571,067**	**$36,013,102**	**$4,416,584**

Based on the estimated FY 2013-14 volumes, general ACLs are projected at $0.31277 and online ACLs are projected at $0.12359. ACLs are paid at different rates depending on the volume level. The average price is a blend of these rates and is determined by the actual annual volume of claims.

FY 2015-16

	General ACLs	Amount	Online-Drug ACLs	Amount
Total ACLs	174,191,262	60,698,073	36,973,234	$4,445,421
Less HFP	0	0	0	0
Total Medi-Cal ACLs	**$174,191,262**	**$60,698,073**	**36,973,234**	**$4,445,421**

Based on the estimated FY 2014-15 volumes, general ACLs are projected at $0.35417 and online ACLs are projected at $0.12157. ACLs are paid at different rates depending on the volume level. The average price is a blend of these rates and is determined by the actual annual volume of claims.

Negotiated Change Orders

Change Order No.	Title/Description	Effective
12	**Diagnosis Related Groups**	10/31/2013

Senate Bill (SB) 853 requires the Department to develop and implement a Medi-Cal payment methodology based on Diagnostic Related Groups (DRG). The DRG reflects the costs and staffing levels associated with quality of care for patients unless otherwise specified. The Department has agreed to reimburse Xerox for all documentable expenses that are as a direct result of efforts to implement the DRG requirement. Reimbursable expenses are for required work that is beyond the scope of the current Fiscal Intermediary Contract with Xerox.

	FY 2014-15	**FY 2015-16**
Change Order Administration:		
Total Funds	$300,000	$200,000
General Funds	$150,000	$100,000
Cost Reimbursement:		
Total Funds	$132,000	$132,000
General Funds	$66,000	$66,000
Total Funds	$432,000	$332,000
General Funds	$216,000	$166,000

DENTAL FISCAL INTERMEDIARY

DENTAL FISCAL INTERMEDIARY

In 1997, the State awarded Delta Dental Plan of California (DDC) a contract which took effect in February of 1998. Full Operations of this contract ended in April 2005. In 2004, the State again awarded Delta (now Delta Dental of California) a contract with Takeover activities commencing on November 1, 2004. Full Operations, including claims processing, began May 1, 2005 and was scheduled to end June 30, 2012. The Department issued a Request for Proposal and published the Notice of Intent to Award in August 2011. However, the Centers for Medicare and Medicaid Services (CMS) determined the new Medi-Cal Dental FI contract failed to meet the regulatory criteria and conditions as a Medicaid Management Information System (MMIS). Subsequently, the Department exercised the one-time extended operations option of the current Dental FI contract for the period of June 1, 2012 through June 30, 2013. The Department has received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension began July 1, 2013 and will go through June 30, 2015. During the extension, the Department has developed a Planning Advanced Planning Document (PAPD), which has been approved by CMS, and will procure a new dental MMIS contract that meets CMS's requirements. All activities related to the new contract have been delayed.

Assembly Bill 82 (Chapter 23, Statutes of 2013) restores select adult dental benefits to beneficiaries 21 years of age and older starting May 1, 2014.

The following covered benefits have been restored:

- Examinations, radiographs/photographic images, prophylaxsis, fluoride treatments
- Amalgam and composite restorations
- Stainless steel, resin, and resin window crowns
- Anterior root canal therapy
- Complete dentures, including immediate dentures
- Complete denture adjustments, repairs, and relines

The Department has received approval for federal financial participation and coverage of the above services.

The terms of the contract require DDC to process and pay claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligibles. There are numerous enhancements to the claims processing system which have been made under the terms of the contract. The three main payment categories for this contract include:

Operations - Operations constitute all contractual responsibilities required for the Contractor to administer and operate the California Dental Medicaid Management Information System (CD-MMIS). These cost categories consist of General Adjudicated Claim Service Lines (ACSLs), Treatment Authorization Requests (TARS), and Telephone Support Center (TSC). DDC has bid on State-specified volume ranges for each of the above categories. The Department estimates Operations costs by applying these bid rates to the projected volumes for the current and budget year.

Cost Reimbursement - Various costs incurred by the Contractor while performing responsibilities under the contract will be reimbursed by the State. These costs are not a part of the bid price of

the contract. Any of the following costs may be cost reimbursed under the contract:

1) Printing,
2) Data center access,
3) Postage, parcel services, and common carriers,
4) Special training sessions, convention, and travel,
5) Audits and research,
6) Facilities improvement,
7) Personal computers, monitors, printers, related equipment, and software,
8) Telephone toll charges,
9) Knox Keene License Annual Assessment, and
10) Miscellaneous.

Costs under these categories consist of direct costs, or a subset thereof, which can be specifically identifiable with the particular cost objective.

Hourly Reimbursement - Certain activities are reimbursed on an hourly basis by the State. The rate paid to the Contractor consists of all direct and indirect costs required to support these activities, plus profit. Hourly reimbursed areas consist of the Systems Group (SG), Surveillance and Utilization Review (SURS) unit, and computer support. The SG staff consists of technical and supervisory staff that design, develop, and implement Department required modifications and/or provide technical support to the California Dental Medicaid Management Information System (CD-MMIS). The SURS staff consists of dental consultants, manager/supervisors, liaisons, and analysts that monitor the provider and beneficiary claims to prevent potential fraud and abuse.

HIPAA – CD-MMIS – HIPAA requires uniform national health data standards, unique identifiers, and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the CD-MMIS and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) were submitted to CMS and were approved for enhanced funding for Transactions. APDs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Adoption of Rules for a Unique Health Plan Identifier (HPID) (In Progress)
- Claims Attachments (Pending)
- Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claims Status Transactions (In Progress)
- Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance (In Progress)
- Adoption of Operation Rules for Connectivity (In Progress)

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased in approach to implement the most critical transactions (in terms of provider impact) and code sets first, without interrupting payments to providers or services to beneficiaries. The July 8, 2011 published HIPAA rules require changes to the Claim Status Transactions and Companion Guides and had a compliance date of January 1, 2013. The

September 5, 2012 published HIPAA rules adopted the standard for a national unique health plan identifier (HPID) and requires changes to CD-MMIS in order to meet the federal compliance date of November 7, 2016.

Medi-Cal Dental FI Contract Turnover – CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension began July 1, 2013 and goes through June 30, 2015. The Department has developed a PAPD, which has been approved by CMS, and will procure a new dental MMIS contract that meets CMS's requirements.

The Department has instructed the FI contractor to resume turnover support services and all activities in accordance with the contract requirements. Turnover activities, previously completed by the Dental FI, have to be redone. As a result, the Turnover bid price must be renegotiated. A change order will be submitted to implement this change.

The Turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in addition to supporting the Department's procurement effort by ensuring that all required data and documentation was included in the Office of Medi-Cal Procurement's data library.

CD-MMIS Takeover by New Dental FI Contractor – The dental FI operates CD-MMIS, which is the Medi-Cal dental claims processing system. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. The Department issued a RFP to establish a new FI contract. In August 2011, the Department evaluated the bids and published the Notice of Intent to Award.

In February 2012, the new dental FI began takeover activities. However, CMS determined the new Medi-Cal Dental FI contract failed to meet the regulatory criteria and conditions as a MMIS. Subsequently, the Department exercised the one-time extended operations option of the current Dental FI contract for the period of June 1, 2012 through June 30, 2013. Additionally, the Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract, extending operations of the current Dental FI contract for the period of July 1, 2013 through June 30, 2015. The Department instructed the FI contractor to stop all Takeover activities. The FI contractor filed a Notification of Claim to recoup costs already expended for Takeover activities. The Department has determined that the FI contractor should be reimbursed and is currently working with CMS to determine if FFP will be available for these costs.

Takeover Activities for the new FI contractor are expected to begin October 1, 2014.

Extension of the Current Medi-Cal Dental FI Contract – CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The Department has developed a PAPD, which has been approved by CMS, and will procure a new dental MMIS contract that meets CMS's requirements.

Fiscal Intermediary Change Orders – A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the FI.

Dental Fiscal Intermediary
November 2014

FY 2014-15

	Total Fund	General Fund
Dental Administration/Operations	$53,876,000	$14,863,042
Telephone Service Center	$25,478,000	$10,764,455
Change Orders	$2,238,000	$1,041,500
Hourly Reimbursable Groups	$12,116,000	$3,029,000
Cost Reimbursable Expenses	$10,684,000	$5,164,250
Contract Turnover	$0	$0
Contract Takeover	$0	$0
Total Dental Administration Costs	**$104,392,000**	**$34,862,247**

Dental Fiscal Intermediary
November 2014

FY 2015-16

	Total Fund	General Fund
Dental Administration Operations	$54,900,000	$15,145,538
Telephone Service Center	$25,962,000	$10,968,945
Change Orders	$2,248,000	$1,044,000
Hourly Reimbursable Groups	$12,298,000	$3,074,500
Cost Reimbursable Expenses	$13,842,000	$6,743,250
Contract Turnover	$75,000	$18,750
Total Dental Administration Costs	**$109,325,000**	**$36,994,983**

DENTAL COST REIMBURSABLE EXPENSES

November 2014

	FY 2014-15		FY 2015-16	
	TF	**GF**	**TF**	**GF**
Printing (50%)	$1,100,000	$550,000	$1,100,000	$550,000
Data Center Access/CPU Usage (25%)	$1,000	$250	$1,000	$250
Postage / Parcel Service (50%)	$1,400,000	$700,000	$1,400,000	$700,000
Special Training,Convention, Travel (50%)	$130,000	$65,000	$130,000	$65,000
Audits / Research (50%)	$170,000	$85,000	$170,000	$85,000
Facilities Improvement (25%)	$110,000	$27,500	$110,000	$27,500
Toll Free Phone Charges (25%)	$600,000	$150,000	$600,000	$150,000
Knox-Keene Annual Assessment (50%)	$2,898,000	$1,449,000	$2,898,000	$1,449,000
Health Insurance Provider Fee (50%)	$3,730,000	$1,865,000	$7,100,000	$3,550,000
Misc. (50%)	$545,000	$272,500	$333,000	$166,500
Total	**$10,684,000**	**$5,164,250**	**$13,842,000**	**$6,743,250**

DENTAL FISCAL INTERMEDIARY
ACSL & TAR PROJECTIONS

November 2014

FY 2014-15 Assumptions

ACSL Projections:	36,325,668	$46,030,000
TAR Projections:	553,924	$7,846,000
		$53,876,000

- Full, ongoing costs will be incurred for all contract pricing components.
- FFP for postage, printing, Knox-Keene and Dental Outreach are funded at 50%.
- Expenditures for all remaining administrative cost categories will be funded at 75% FFP.

FY 2015-16 Assumptions

ACSL Projections	37,052,181	$46,730,000
TAR Projections	565,002	$8,170,000
		$54,900,000

- Full, ongoing costs will be incurred for all contract pricing components.
- FFP for postage, printing, Knox-Keene and Dental Outreach are funded at 50%.
- Expenditures for all remaining administrative cost categories will be funded at 75% FFP.

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
7	***Conlan, Schwarzmer, Stevens vs. Bontá***	7/1/2007

In the case of *Conlan, Schwarzmer, Stevens v. Bontá,* the Court of Appeals found that the Department failed to provide a procedure whereby Medi-Cal beneficiaries can be reimbursed for their out-of-pocket expenses for health care received during their period of retroactive eligibility and during the period between their application for Medi-Cal and their determination of eligibility. The Court held that the Department's system of relying upon the beneficiaries to obtain reimbursement from the providers for these expenses is insufficient, because it violates the comparability provisions of the Medicaid law.

The Department has developed and implemented new processes through the Dental fiscal intermediary (FI) to ensure prompt reimbursement to beneficiaries. The Dental FI is required to hire, train, and oversee appropriate staff to address this new workload. Costs have been updated based on the current workload volume the Dental FI is receiving.

	FY 2014-15	**FY 2015-16**
Total Funds	$115,000	$115,000
General Funds	$57,500	$57,500

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
9	**Health Insurance Portability and Accountability Act (HIPAA) Addendum - Security Risk Assessment**	8/1/2007

This change order establishes the Department's implementation plan designed to comply with the controls required by the National Institute of Standards and Technology (NIST). Special Publication 800-53 adds to the framework of OMB Circular No. A-130. Compliance with the NIST controls will result in increased requirements to the Security and Privacy Laws and regulations required by Contract 04-35745, Exhibit H, the HIPAA Business Associate Addendum. The results of this change order will be the implementation of a security risk assessment process for all current and future projects.

	FY 2014-15	**FY 2015-16**
Total Funds	$310,000	$320,000
General Funds	$77,500	$80,000

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
23	**Federal Rule – Revalidation of Provider Enrollment**	6/1/2013

Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal Dental Program. The new rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

To work towards compliance, the Department has hired additional FI staff to complete the increased workload. The change order was approved in May 2013 and became effective June 2013. The FI recruited additional staff and started incurring costs beginning October 2013.

	FY 2014-15	**FY 2015-16**
Total Funds	$1,438,000	$1,438,000
General Funds	$719,000	$719,000

Negotiated Change Orders

Change Order No.	Title/ Description	Effective
24	**Federal Rule – Database Checks**	6/1/2013

Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal Dental Program. The new rules establish requirements for screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

To work towards compliance, the Department has hired additional FI staff to complete the increased workload. The change order was approved in May 2013 and became effective June 2013. The FI recruited additional staff and started incurring costs beginning October 2013.

	FY 2014-15	**FY 2015-16**
Total Funds	$375,000	$375,000
General Funds	$187,500	$187,500

MISCELLANEOUS

EXPENDITURES

CALIFORNIA STATE CONTROLLER AND CALIFORNIA STATE TREASURER AGREEMENTS

Pursuant to an interagency agreement with the Department, the California State Controller's Office (CSCO) issues warrants to Medi-Cal providers and the California State Treasurer's Office (CSTO) provides funds for warrant redemption.

CSCO Assumptions

- 75% FFP is claimed for CSCO costs related to warrant and Remittance Advice Detail (RAD) production. Due to all costs associated with the Medically Indigent Adult SNF cases being 100% payable from the General Fund, the net effective FFP ratio is 74.9%.
- 50% FFP is claimed for postage costs.
- 100% FFP is claimed for auditing services.

CSTO Assumptions

- 75% FFP is claimed for all CSTO costs related to warrant redemption services.

FY 2014-15 Estimate	Total	GF	FFP
CSCO			
Warrants & RADs	$793,617	$198,404	$595,212
Postage	$981,383	$490,692	$490,692
SCO Total	**$1,775,000**	**$689,096**	**$1,085,904**
CSTO			
Warrant Redemption	$80,652	$20,163	$60,489
TOTAL	**$1,855,652**	**$709,259**	**$1,146,393**

FY 2015-16 Estimate	Total	GF	FFP
CSCO			
Warrants & RADs	$798,750	$199,688	$599,063
Postage	$976,250	$488,125	$488,125
SCO Total	**$1,775,000**	**$687,813**	**$1,087,188**
CSTO			
Warrant Redemption	$80,652	$20,163	$60,489
TOTAL	**$1,855,652**	**$707,976**	**$1,147,677**

PROVIDER VERIFICATION FILE

Pursuant to an interagency agreement with the California Department of Consumer Affairs, Medical Board of California, the Department purchases licensure data. This data gives the Department the ability to verify that prospective providers are currently licensed prior to enrollment in the Medi-Cal program. It also enables the Department to verify the validity of the referring provider license number on Medi-Cal claims.

	FY 2014-15	FY 2015-16
Total Funds	$2,466	$2,466
General Funds	$617	$617

HIPAA PROJECT SUMMARY

The Department's Medi-Cal fiscal intermediary HIPAA costs are displayed within the Systems Group (SG), Change Order (CO), and Cost Reimbursement (CR) for the HP and Delta Dental contracts and for the Maximus contract as follows:

	FY 2014-15	FY 2015-16
Total Funds	$23,893,979	$11,256,241
General Funds	$3,936,284	$2,867,155

	FY 2014-15		FY 2015-16	
	Total Funds	GF	Total Funds	GF
Medi-Cal Fiscal Intermediary				
Code Conv/Secur/Trans (SG)	$7,091,550	$1,710,315	$9,594,450	$2,482,043
ICD-10 HIPAA Medical Coders HIPAA-2 (CR)	$605,740	$71,477	$208,000	$24,544
Code Conversion Proj Mgr HIPAA-1 (CR)	$19,500	$4,875	$234,000	$23,400
ICD-10 Gap Analysis	$1,283,330	$128,333	$0	$0
ICD-10 Enhancements	$13,209,530	$1,582,502	$0	$0
IV&V Contractor for HIPAA 5010 & ICD-10	$150,000	$17,700	$40,000	$4,720
HIPAA & State Privacy Breach Notification	$150,000	$75,000	$150,000	$75,000
Code Management Tool - Sof	$450,000	$112,500	$0	$0
HIPAA ICD-10 PM	$324,329	$81,082	$269,791	$67,448
Code Management Tool - Tra	$50,000	$12,500	$0	$0
Total Medical FI	**$23,333,979**	**$3,796,284**	**$10,496,241**	**$2,677,155**
Dental				
HIPAA Security (CO)	$310,000	$77,500	$320,000	$80,000
Development – CDT (SG) 25%	$250,000	$62,500	$440,000	$110,000
HIPAA 2 (SG)	$0	$0	$0	$0
HIPAA Operating Rules (SG) 25%	$0	$0	$0	$0
HIPAA EFT and Remittance Advice 25%	$0	$0	$0	$0
Total Dental FI (Delta)	**$560,000**	**$140,000**	**$760,000**	**$190,000**
HCO				
NPI (CR)	$0	$0	$0	$0
Total HCO FI (Maximus)	$0	$0	$0	$0
Total HIPAA	**$23,893,979**	**$3,936,284**	**$11,256,241**	**$2,867,155**

Does not include HIPAA support costs or FFP for other departments' HIPAA costs, which are budgeted in the Other Administration tab of the Estimate.

MEDI-CAL ASSUMPTIONS
November 2014
FISCAL YEARS 2014-15 & 2015-16

INTRODUCTION

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction, and is derived from a 36-month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Estimate.

Note: A list of acronyms and abbreviations has been provided following the Assumptions Section.

FEE-FOR-SERVICE BASE ESTIMATES

The FFS base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and $/claim or $/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

	USERS	=	f(TND, S.DUM, O.DUM, Eligibles)
	CLAIMS/USER	=	f(TND, S.DUM, O.DUM)
	$/CLAIM	=	f(TND, S.DUM, O.DUM)
WHERE:	USERS	=	Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	=	Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	$/CLAIM	=	Total monthly $ divided by total monthly claims or units by service and aid category.
	TND	=	Linear trend variable.
	S.DUM	=	Seasonally adjusting dummy variable.
	O.DUM	=	Other dummy variable (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.)

Eligibles	=	Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

Following the estimation of coefficients for these variables during the period of historical data, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, claims/user and $/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA establishes a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the former practice of using various income disregards to adjust family income was replaced with a single 5% income disregard. The ACA simplifies the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons did not change.

The new standard allows current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

In addition, the ACA imposes a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled, in Medi-Cal to enroll in the program. The Department expects this expansion group and the currently eligible but not enrolled population to result in a significant number of new Medi-Cal beneficiaries.

For those newly eligible adults in the expansion group, the ACA provides California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled, in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA will increase the CHIP FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

In response to the federal ACA mandate and State legislative direction, the Department chose the HHS Secretary-approved plan option, which allows DHCS to seek approval for the same full scope Medi-Cal benefits received by existing beneficiaries. This option requires the selection of a private market reference plan to define the Essential Health Benefits (EHB) offered in the Alternative Benefit Plan (ABP).

The Standard Blue Cross/Blue Shield PPO (FEHB) Plan was selected as the EHB reference plan, as it allows DHCS to provide an ABP package that most closely reflects existing State Plan benefits and thereby avoids disparity between the benefits received by new and existing beneficiaries.

HOME AND COMMUNITY BASED SERVICES

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

IHSS helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must meet at least one of the following:

- 65 years of age or older,
- Disabled,
- Blind, or
- Have a medical certification of chronic, disabling condition that causes functional impairment expected to last 12 consecutive months or longer or result in death within 12 months and unable to remain safely at home without the services.

Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. Personal Care Services Program (PCSP)
   This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective supervision.
2. IHSS Plus Option (IPO)
   This program provides personal care services but also allows the recipient of services to select a family member as a provider.
3. Community First Choice Option (CFCO)
   This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment;
- Development of an individualized service plan;
- Linkage and consultation;

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- Assistance with accessing services;
- Crisis assistance planning;
- Periodic review.

Waivers

Medi-Cal operates and administers various home and community-based services (HCBS) waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary state plan services are less than the total cost incurred at the otherwise appropriate facility plus state plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS), Assisted Living (ALW), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), HCBS Waiver for Persons with Developmental Disabilities, San Francisco Community Living Support Benefit (CLSB), and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

Assisted Living Waiver (ALW)

The ALW pays for assisted services and supports, care coordination, **and** community transition~~, and home modification~~ in ~~ten~~ **11** counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, ~~and~~ San Diego**, and Kern**). **Coverage into three additional counties (Orange, San Mateo and Santa Clara) is anticipated upon approval from CMS.** Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE) or through a home health agency while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is 3,700 ~~in 2013 and 2014~~. The waiver ~~is~~ **was** approved from March 1, 2009 through February 28, 2014; a proposal to renew the waiver for an additional five years was submitted to CMS on November 27, 2013~~, with an anticipated effective date of March 1, 2014~~. **The ALW is currently operating under extension through August 28, 2014. The five-year term of the waiver will be March 1, 2014 through February 28, 2019.**

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. A lawsuit was filed challenging elimination of ADHC (*Darling et al. v. Douglas et al.*), resulting in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. CBAS provides necessary medical and social services to individuals with intensive health care needs. CBAS became effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver; the CBAS portion ~~ends on August 31, 2014. Former ADHC participants and new eligible~~ **continues through the life of the 1115 Demonstration. Eligible** participants who meet the more stringent CBAS eligibility standards receive CBAS in approved CBAS centers. ~~CBAS was provided through Medi-Cal FFS effective~~

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~~April 1, 2012 and continues to be provided to eligible participants residing in non-managed care counties, or to eligible participants who are exempted from, or ineligible for enrollment in a managed care plan. As of October 1, 2012, CBAS was transitioned into all managed care health plans.~~ **CBAS has been provided to all eligible participants since April 1, 2012.** There is no cap on enrollment into this waiver service. ~~The Department is seeking to amend the BTR 1115 waiver extending CBAS through the life of the waiver.~~

In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed LOC. The waiver is approved from January 1, 2010 through December 31, 2014. The Department will submit a renewal to CMS requesting an extension of the waiver from January 1, 2015 through December 31, 2019.

Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver

Effective December 1, 2012, the Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver was merged with the Nursing Facility/Acute Hospital (NF/AH) Waiver, based on CMS approval. The newly merged waiver was renamed the Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver. Under the NF/AH – Transition and Diversion Waiver, current DD/CNC participants will continue receiving their existing services and the DD/CNC providers will continue to be reimbursed at the pre-existing DD/CNC daily per diem rates.

The NF/AH – Transition and Diversion Waiver provides Medi-Cal beneficiaries with long-term medical conditions, who met the acute hospital, adult, or pediatric subacute, nursing facility, distinct-part nursing facility (NF) Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization.

The waiver is approved from January 1, 2012 through December 31, 2016.

San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements Assembly Bill 2968 (Chapter 830, Statutes of 2006) which allows the San Francisco Department of Public Health (SFDPH) to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. A person eligible for the CLSB Waiver must:

- Be a resident of the city and county of San Francisco.
- Be at least age 21 years or over.
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations.

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- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting.
- Have one or more medical co-morbidities.
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

CLSB Waiver community settings are limited to State-approved housing, which includes community care facilities licensed by the California Department of Social Services, Community Care Licensing, and Direct Access to Housing (DAH) sites operated by SFDPH.

CLSB Waiver services consist of Care Coordination, Enhanced Care Coordination, Community Living Support Benefit in licensed settings and DAH sites, Behavior Assessment and Planning, Environmental Accessibility Adaptations in DAH sites, and Home delivered meals in DAH sites.

The SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, CMS approved a waiver amendment on September 23, 2013 which adjusted enrollment estimates. The waiver is approved from July 1, 2012 through June 30, 2017.

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

Services provided include:

- Administrative Expenses;
- Attendant care;
- Case management;
- Financial supplements for foster care;
- Home-delivered meals;
- Homemaker services;
- In-home skilled nursing care;
- Minor physical adaptations to the home;
- Non-emergency medical transportation;
- Nutritional counseling;
- Nutritional supplements;
- Psychotherapy;
- ~~Specialized medical equipment and supplies.~~

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an “Aid Code” with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS adults who are certified by the nurse case manager to be at the nursing facility

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level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Approved capacity of unduplicated recipients for this waiver is ~~4,410 in 2013,~~ 4,490 in 2014, ~~and~~ 4,570 in 2015 **and 4,660 in 2016**. The waiver is approved from January 1, 2012 through ~~January~~ **December** 31, 2016.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with local agencies statewide to provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and be certified or certifiable for placement in a nursing facility. Services provided by MSSP include: adult day care / support center, housing assistance, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. ~~Approved~~ **Pending CMS approval,** capacity of unduplicated recipients for this waiver ~~is 13,080 for 2013 and~~ **will be 12,000 in** 2014 **and 9,093 in 2015**. The waiver is approved from July 1, 2009 through ~~June 30, 2014~~ **September 30, 2014**. Pursuant to the Coordinated Care Initiative, the Department will submit an amendment to CMS requesting the inclusion of MSSP as a managed care component; the Department will also request the renewal of the waiver from ~~July 1~~ **October 1**, 2014 through ~~June 30~~ **September 30**, 2019.

Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)

The DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the mentally retarded; in California, Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. Approved capacity of unduplicated recipients for this waiver is 110,000 in 2013, 115,000 in 2014 and 120,000 in 2015. The waiver is approved from ~~October 1, 2011 through September 30, 2016~~ **March 29, 2012 through March 28, 2017**.

Pediatric Palliative Care (PPC) Waiver

The PPC provides children hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and Family Unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009 through March 31, 2012. The CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years

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effective April 1, 2012 through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800.

Managed Care Programs

Program of All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services**.** PACE covered services include all medical, long-term services and supports, dental, vision and other specialty services**,** allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities**.** Participants must be 55 years or older and determined by the Department to meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place. The Department has statutory authority to contract with up to 15 PACE organizations.

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease. The Department has renewed the SCAN contract through December 31, ~~2014~~ **2015**.

Special Grant

California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a Money Follows the Person Rebalancing Demonstration Grant, called ~~the~~ California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. Grant funds may be requested from January 1, 2007, through September 30, 2016. The grant requires the Department to develop and implement strategies for transitioning Medi-Cal beneficiaries who have resided continuously in health care facilities for three months or longer back to a federally-qualified residence**.**

1115 WAIVER-MH/UCD & BTR

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and a new demonstration was approved by CMS.

The California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) was approved effective November 1, 2010, for five years. This Demonstration extends and modifies the previous MH/UCD. Many of the features of the previous Demonstration have been continued with modifications as noted in the individual assumptions. There is no new funding for the South LA Preservation Fund and the Distressed Hospital Fund. Other significant changes in the new Demonstration are:

- Expansion of the state-only programs that may be federalized up to a maximum of $400 million in each year of the waiver;
- Creation of a Delivery System Reform Incentive Pool (DSRIP) fund to support public hospital efforts in enhancing quality of care and health of patients;
- Expansion of the current Health Care Coverage Initiative (HCCI) by creating a separate Medicaid Coverage Expansion (MCE) program using new funding for those eligibles who have family income at or below 133% of the Federal Poverty Level.

The BTR will end on October 31, 2015. The Department plans to work with CMS to extend this Demonstration and/or submit a waiver renewal concept for 2015-16 and beyond. The Department assumes that all existing BTR Demonstration funding will continue.

MANAGED CARE

Medi-Cal Managed Care Rates

Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months and plans' self-reported utilization and encounters by category of service (i.e., Inpatient, ER, Pharmacy, PCP, Specialist, FQHC, etc.) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The delivery events and associated maternity costs are carved out of the Family/Adult, and Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid categories to establish a budget neutral county specific maternity supplemental payment.

Trend studies are performed and policy changes are incorporated into the rates. Medi-Cal specific financial statements are gathered for each plan for the last five quarters. Administrative loads are developed based upon a Two-Plan program average. Plan specific rates are established based upon all of the aforementioned steps.

A financial experience model is developed by trending plan specific financial data to the mid-point of the prospective rate year. The financial experience is then compared to the rate results established through the rate development model. If the result is reasonable, the rates are established from the rate development model. If the result is not reasonable, additional research is performed and the rates are adjusted based upon the research and actuarial judgment.

The maternity supplemental payments are in addition to the health plan's monthly capitation payment and are paid based on the plan's reporting of a delivery event. Maternity supplemental payment amounts are done in a budget neutral manner so that the cost of the expected deliveries does not exceed the total dollars removed from the Adult/Family and Disabled Medi-Cal Only capitation rates.

Capitation rates are risk adjusted to better reflect the match of a plan's expected costs to the plan's risk. Capitation rates are risk adjusted in the Family/Adult and Aged /Disabled/Medi-Cal Only Categories of Aid (COAs).

Risk Adjustment and County Averaging is prepared with plan specific pharmacy data (with NDC Codes) gathered for Managed Care and FFS enrollment data for the most recent 12 month period. A cut-off date is established for the enrollment look-back. If a beneficiary is enrolled for 6 of the 12 months (not consecutively), then the beneficiary is counted in the plan's risk scoring calculation.

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Family/Adult or SPD Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate.

MANAGED CARE

The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2013-14 rates, 40% of this county specific rate was taken and multiplied by each plan's respective risk score and 60% of each plan's plan specific rate was retained and added to the 40% risk adjusted rate to establish a risk adjusted plan specific rate. The risk adjustment policy will be examined in future years and adjusted if determined necessary.

For County Organized Health Systems, rates continue to be based on the plans' reported expenditures trended in the same manner as for the Two Plan and GMC models.

Fee-for-Service Expenditures for Managed Care Beneficiaries

Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to FQHC/RHC providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

For further information, see policy change FFS Costs for Managed Care Enrollees.

2013-14 and 2014-15 Rates

Overall, the rates represent a 3.63% increase in FY 2013-14 over the previous fiscal year rates (based on a fiscal year comparison). Rates for 2014-15 represent a 3.5% increase over the 2013-14 fiscal year rates.

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility. Rates are updated annually and are established based on the most recent cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personnel activities. Costs are limited to the 90th percentile of each facility's peer group.

- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90th percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75th percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50th percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

PROVIDER RATES

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

Quality and Accountability Supplemental Payment Program

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.

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Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped by location. Reimbursements are equal to the median of each peer group.

PROVIDER RATES

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Effective ~~August 1, 2012~~**June 2014**, providers of services to developmentally disabled clients have rates set as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65th percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65th percentile.

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

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REVENUES

1. Revenues

The State is expected to receive the following revenues from quality assurance fees (accrual basis):

FY 2013-14:	$ 35,640,000	ICF-DD Quality Assurance Fee
	$ ~~504,407,~~000 **503,813,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ 7,361,000	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ ~~1,204,000~~ **1,793,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$ 798,599,000	MCO Tax
	$~~3,664,901,000~~ **3,695,728,000**	Hospital Quality Assurance Revenue Fund (4260-610-3158)
	$ 11,250,000	Emergency Medical Air Transportation Fund (EMATA)
	$~~5,023,362,000~~ **5,054,184,000**	Total
FY 2014-15:	$ 25,742,000	ICF-DD Quality Assurance Fee
	$ ~~509,837,000~~ **522,095,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ ~~7,464,000~~ **7,358,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ ~~1,218,000~~ **1,862,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$ ~~1,481,657,000~~ **1,432,849,000**	MCO Tax
	$ ~~3,992,473,000~~ **3,991,796,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	$ 11,250,000	Emergency Medical Air Transportation Fund (EMATA)
	$~~6,029,641,000~~ **5,992,952,000**	Total
FY 2015-16:	$ **25,742,000**	ICF-DD Quality Assurance Fee
	$ **535,233,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	$ **7,358,000**	ICF-DD Transportation/Day Care Quality Assurance Fee
	$ **1,862,000**	Freestanding Pediatric Subacute Quality Assurance Fee
	$ **2,124,756,000**	MCO Tax
	$ **4,600,535,000**	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)

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$ **11,250,000**	Emergency Medical Air Transportation (EMATA) Fund
$**7,306,736,000**	Total

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee is assessed, to include Medicare for AB 1629 facilities.
The FY 2011-12 ICF/DD Transportation/Day Care QA fee includes a one-time retroactive collection of $22.5 million in QA fees for FY 2007-08 through FY 2010-11. In addition to the retroactive QA fees, the QA fee includes an estimated $6.1 million for FY 2011-12. The ICF/DD Transportation/Day Care QA fee is expected to remain consistent in future years.

Effective January 1, 2012, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department will implement a QA fee from Freestanding Pediatric Subacute Care facilities, pending CMS approval.

AB 1422 (Chapter 157, Statutes of 2009) has imposed an additional tax on the total operating revenue of all Medi-Cal managed care plans. The provision pertaining to this tax will be effective retroactive to January 1, 2009 until June 30, 2012. The Department is proposing legislation that will eliminate the gross premium tax sunset date on the total operating revenue of Medi-Cal managed care plans. The permanent extension of the tax will generate additional General Fund revenue.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund will be used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund will also be used to pay for health care coverage for children, staff and related administrative expenses required to implement the QAF program.SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to enactment of a new hospital QAF that results in FY 2011-12 revenue for children's services of at least $320 million.

SB 335 (Chapter 286, Statues of 2011) authorizes the implementation of a new Hospital Quality Assurance Fee (QAF) program for the period of July 1, 2011 to December 31, 2013. This new program will authorize the collection of a quality assurance fee from non-exempt hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue and will be used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

SB 239 (Chapter 657, Statutes of 2013) extended the Hospital QAF program from January 1, 2014 through December 31, 2016. This extension will authorize the collection of a

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quality assurance fee from non-exempt hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue and will be used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed health care plans. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which will result in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of $4 for convictions involving vehicle violations.

2. Redevelopment Agency and Local Government Funds

The amended 2009 Budget Act included a $3.6 billion expenditure transfer of Redevelopment Agency and local government funds to the General Fund to offset General Fund expenditures. Of the $3.6 billion transfer, $572,638,000 has been attributed to the Medi-Cal program for accounting purposes. The transfer provides funds directly to the General Fund, and cash does not flow through the Department of Health Care Services. The transfer does not affect Medi-Cal payments or the estimate.

ELIGIBILITY

3. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The current sunset date has been extended to ~~December 31, 2013~~ **March 31, 2015,** by HR ~~3630~~, **4302,** the ~~Middle Class Tax Relief and Job Creation Act of 2012.~~ **Protecting Access to Medicare Act of 2014.**

4. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children

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who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. The current sunset date has been extended ~~February 29, 2012~~ **March 31, 2015**, by HR ~~3765~~, the ~~Temporary Payroll Tax Cut Continuation Act of 2011~~. **Protecting Access to Medicare Act of 2014.**

5. Impact of SB 708 on Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected in FY 2012-13 and FY 2013-14 due to the spending limit.

6. *Ledezma v. Shewry* Lawsuit

The Department negotiated a settlement of *the Ledezma v. Shewry* lawsuit. The suit resulted from a system programming error that discontinued Qualified Medicare Beneficiaries (QMB) at annual re-determination. Eligibility for Medicare Part A has been restored and affected beneficiaries have been reimbursed for the cost of their premiums. The Department remains responsible for the cost of reimbursing out-of-pocket medical expenses for qualified claims. Settlement costs are not significant. The parties determined the scope of the Department's liability by contacting beneficiaries who may have incurred out-of-pocket expenses. Beneficiary reimbursements and costs associated with the beneficiary reimbursement process are not eligible for federal matching funds.

7. Electronic Asset Verification Program

Due to the requirements imposed by H.R. 2642 of 2008,the Department is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD) applicants/beneficiaries through electronic requests to financial institutions. The Department will enter into a contract with a financial vendor that will enable the counties to receive asset information for the ABD population. The financial vendor will provide counties with data from financial institutions that could indicate assets and property not reported by the applicant or beneficiary. The counties will have the responsibility to require the applicant or beneficiary to provide additional supporting documentation before an eligibility determination is made. There will be undetermined costs for a third party contract as well as reimbursements to financial institutions. Although savings from asset and eligibility verification are currently indeterminate, savings/cost avoidance will be achieved when

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supplemental data increases the accuracy of eligibility determinations for the ABD population. The implementation date of this program is currently unknown.

8. Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families, and the regional centers to transition residents to community living arrangements. If eligible for Medi-Cal, residents moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system. It is not known when the transitions will begin.

9. Medi-Cal Inpatient Services for Inmates

AB 720 (Chapter 646, Statutes of 2013) ~~authorizes~~ **requires** the suspension of Medi-Cal benefits for all Medi-Cal eligible inmates, regardless of age. This new state law authorizes county boards of supervisors, in consultation with the county sheriff, to designate an entity or entities to act on behalf of county inmates and assist county jail inmates apply for a health insurance affordability program.

AFFORDABLE CARE ACT

10. Realignment

Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public /non-County Medical Services Program counties ~~will~~ have ~~the option to select~~ **selected** one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for the public hospital county Medi-Cal and uninsured population and non-public/non-CMSP county indigent population. Option 2 is redirection of 60% of a county's health realignment allocation plus 60% of the maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) as amended by Senate Bill 98 (Chapter 358, Statutes of 2013) lays out the methodology for the formula in option 1, and requires the department to perform the calculation. AB 85 also sets targets, and a process to meet the targets, for the number of newly eligible Medi-Cal enrollees who will be default assigned to County Public Hospital health systems as their managed care plan primary care provider.

The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be ~~$300 million in FY 2013-14, and $900~~ **$724.9** million in FY 2014-15 **and FY 2015-16**.

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11. Disproportionate Share Hospital Reduction

The ACA reduction in the Disproportionate Share Hospital (DSH) allotments was to have gone into effect on October 1, 2013: instead, ~~House Joint Resolution 59,~~ **HR 4302 (2014)** ~~passed by Congress and signed by the President~~ **was enacted** on ~~December 26, 2013~~ **April 1, 2014**, **which** delays the reduction until October 1, ~~2015~~ **2016**. The ACA nationwide reduction of State DSH allotments will occur in FY ~~2015-16~~ **2016-17**. The reduction for each state will be determined by CMS.

For federal fiscal year 2017, an aggregate of $1.8 billion in reduction for all states has been determined, but state specific reductions have not been released by CMS.

12. IRS Reporting for Medi-Cal Minimum Essential Coverage

Beginning in 2014, the Affordable Care Act (ACA) required most U.S citizens and legal residents to have qualifying health insurance coverage or pay a tax for not carrying insurance, known as the individual mandate. Internal Revenue Code Section 6055 finalized and published by the Internal Revenue Service (IRS) on March 10, 2014 requires that all State Medicaid Agencies meet the information reporting requirements to support the individual mandate reporting. The Department is required to comply with the minimum essential coverage reporting requirements for tax year 2015. The state will be subject to a penalty if it does not show good faith in attempting to implement these new reporting requirements. The Department is still researching the fiscal impact and options on the best way to implement/leverage a system for this new reporting requirement.

BENEFITS

12. State-Only Anti-Rejection Medicine Benefit Extension

Assembly Bill 2352 (Chapter 676, Statutes of 2010) requires Medi-Cal beneficiaries to remain eligible for State-Only Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant unless, during that time, the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. Currently, some patients qualify for Medi-Cal under a federal rule allowing coverage for anti-rejection medication for one year post organ transplant. After this eligibility ends, the Department will no longer receive FFP. Therefore, the costs for extending this benefit will be 100% General Fund. The fiscal impact is indeterminate.

13. CDSS IHSS Share-of-Cost Buyout

The CDSS and the Department implemented a process that enabled Medi-Cal IHSS recipients who had a Medi-Cal SOC higher than their IHSS SOC to pay the IHSS SOC. Without the payment from CDSS each IHSS recipient with a Medi-Cal SOC that exceeded his/her IHSS SOC was required to meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

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An Interagency Agreement between CDSS and CDHS established the process for the transfer of CDSS funds to prepay the Medi-Cal SOC for IHSS recipients.

Effective October 2009, the SOC Buy-Out provision ended, however the reconciliation process of outstanding claims will continue up to the allowable claiming period.

HOME & COMMUNITY BASED-SERVICES

14. AB 398—Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project. Instead, the Department is exploring ways to serve this population through the Assisted Living Waiver.

15. Assisted Living Waiver ~~Expansion~~ **Rate Structure**

This assumption has been deleted as this is now a new assumption.

16. Medicaid Health Home Services Benefits

The Medicaid Health Home Services Program was authorized by AB 361 (Chapter 642, Statutes of 2013). This program would manage medically complex patients with patterns of high utilization and multiple chronic conditions who could benefit from intensive primary care services. Implementation of health homes includes focused provider technical assistance for in-depth individual primary care practice transformation assistance. Health home services include comprehensive care coordination and patient and family support. Since the program is in its early planning stages, the earliest possible program implementation will be in 2016. Funding will be 90% Federal Funds and 10% State General Funds for the first two years of this program. Thereafter, funding will be 50% Federal Funding and 50% State General Funding.

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

16. Average Acquisitions Cost as the New Drug Reimbursement Benchmark

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. First Databank, the Department's primary drug price reference source ceased publishing AWP as of September 2011. AB 102 (Chapter 29, Statutes of 2011) gave the Department the authority to establish and implement a new

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methodology for Medi-Cal drug reimbursement that is based on average acquisition cost (AAC). If CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the new statute. To ensure the benchmark is in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.

17. Federal Upper Limit

The Deficit Reduction Act (DRA) of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175% of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated. These changes will result in an indeterminate change in the amount the Department reimburses for generic drugs. On May 23, 2011, CMS reported that a notice of proposed rulemaking (NPRM) implementing the changes to AMP had been drafted and was under review. The Department plans to implement the FULs, after federal regulations have been published and/or final FULs are provided by CMS.

DRUG MEDI-CAL

18. Naltrexone Treatment Services

Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and substance use disorder diagnoses. Naltrexone blocks the euphoric effects of opioids and helps prevent relapse to opioid use. Naltrexone services are not provided to pregnant women. While these benefits are available, beneficiaries are currently not utilizing the service.

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

19. Change in PACE Rate Methodology

Currently, plan specific Program of All-Inclusive Care for the Elderly (PACE) experience and utilization is not taken into account when setting PACE rates. Instead the Department is required by Section 14593 (e)(1) of the W&I Code to set PACE rates using a fee-for-service (FFS) equivalent cost rate methodology. This is not in alignment with the plan specific cost and experience based rate methodology utilized for other managed care health plan models contracting with the Department. The scope of the rate methodology utilized for managed care health plans is defined in Section 14301.1 of the W&I Code. In addition, the Department has consistently worked to communicate to the PACE organizations that due to the transition of these

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populations into managed care, there is not enough FFS cost experience to sustain the current FFS equivalent cost methodology to set PACE capitation rates.

The Department plans to develop rates based on plan specific cost, service utilization and quality and performance based measures. The Department will implement this cost/experience based rate setting methodology effective January 1, 2016. This proposal will give the Department the ability to avoid credibility issues with the existing FFS/UPL methodology due to eroding FFS population and accurately evaluate cost-effectiveness of the PACE program in comparison to the CCI managed care plans when serving like populations.

PROVIDER RATES

20. Martin Luther King, Jr. Hospital (MLK) - Inpatient Hospital Funding

Pursuant to SB 857 (Chapter 31, Statutes of 2014), Welfare and Institutions Code (W&I) Section 14165.50, the cost-based reimbursement methodology for fee-for-service (FFS) and managed care Medi-Cal payments to the new MLK hospital will provide compensation at a minimum of 100% of the projected costs for each fiscal year (FY), contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide each fiscal year through FY 2016-17 a guaranteed level of 77% of the projected Medi-Cal costs for inpatient hospital services. Managed care rates must be adjusted to reflect the actuarial equivalent of those costs, subject to specified requirements. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77% of projected Medi-Cal costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77% of costs. Similar requirements are extended to FY 2017-18 and subsequent years at 72% of projected cost.

SUPPLEMENTAL PAYMENTS

21. Designated Public Hospitals – Seismic Safety Requirements

AB 303 (Chapter 428, Statutes of 2009) authorizes Medi-Cal supplemental reimbursement to Designated Public Hospitals for debt service incurred for the financing of eligible capital construction projects to meet seismic safety requirements.

Eligible projects will be limited to meeting seismic safety deadlines, and will include those new capital projects funded by new debt for which final plans have been submitted to the Office of Statewide Health Planning and Development after January 1, 2007, and prior to December 31, 2011.

There will be no expenditures from the State General Fund for the nonfederal share of the supplemental reimbursement. The nonfederal share will be comprised of either certified public expenditures or intergovernmental transfers.

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The Department is assessing federal approval requirements for implementation of this supplemental payment program. Implementation will occur only if federal approvals are obtained and federal financial participation is available.

22. Hospital Inpatient Rate Freeze

The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.

OTHER: AUDITS AND LAWSUITS

23. **SB 1103 Litigation**

- *Mission Hospital Regional Medical Center and Kaiser Foundation Hospitals et al. v. Douglas*

  Approximately 100 California hospitals filed litigation in 2005 to challenge the validity of a limit on Medi-Cal reimbursement for FY 2004-05 for non-contract hospitals, which was enacted by SB 1103 (Chapter 228, Statutes of 2004). Plaintiffs contend the SB 1103 reimbursement limit violates the federally approved State Plan and various federal Medicaid laws, including 42 United States Code (U.S.C.) section 1396a(a)(30)(A), as well as the due process clause and contracts clause of both the United States and California constitutions.

  The trial court issued an order June 19, 2009 that required the Department to recalculate the rates for the plaintiff hospitals for FY 2004-05 without applying the SB 1103 limit and pay them the additional money they would be owed. The Department appealed, and the Court of Appeal reversed the trial court's order. At a hearing on April 27, 2012, the trial court denied the plaintiffs' motion to amend their lawsuit to state a claim for money based on the state recalculating their rates for FY 2004-05 without applying the SB 1103 limit. On April 30, 2013, the trial court issued a final judgment that specified the Department was not required to recalculate rates that were originally determined based on the SB 1103 limit. However, 70 of the hospitals that were plaintiffs in the 2005 lawsuit, filed a new lawsuit in November 2011 in which they again challenge the validity of the SB 1103 reimbursement limit and the new lawsuit specifically seeks a court order to require the Department to recalculate rates for FY 2004-05 without applying the SB 1103 reimbursement limit. ~~Litigation has been stayed while some of the plaintiff hospitals decide whether to dismiss their participation in this lawsuit.~~ **The hospitals subsequently filed a dismissal of the new lawsuit in early 2014.**

- ***OAHA Administrative Appeals and Superior Court Actions***

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In 2005, approximately 100 California hospitals sued the Department to challenge the validity of a Medi-Cal reimbursement rate limit for in-patient services provided by non-contract hospitals that was enacted by Senate Bill 1103 (See *Mission Hospital Regional Medical Center v. Douglas*, above). During the pendency of this litigation, more than 50 non-contract hospitals filed administrative appeals with the Department's Office of Administrative Hearings and Appeals (OAHA). The 50 some hospitals include both *Mission* litigants and non-*Mission* litigants. All challenge SB 1103's validity and, so, seek a retroactive reimbursement rate increase for FY 2004-05, based on SB 1103's alleged invalidity.

OAHA has been holding these administrative appeals in abeyance during the *Mission* litigation, which finally terminated in early 2014. Since 2013, OAHA has dismissed at least 17 of the SB 1103 administrative appeals on the grounds that these appeals are precluded by *res judicata*, that is, by the *Mission* litigation's challenge to SB 1103. In five cases, the hospital has ordered the administrative record but the petition for writ of mandate has not yet been filed. In 12 cases, the dismissed hospitals have filed petitions for writ of mandate with the Los Angeles County Superior Court seeking to compel OAHA to order the Department to recalculate their reimbursement rate and pay the increased rate. In three such cases, the superior court denied the writ petition and the hospitals have appealed. (*Dignity Health v. Douglas*; *Hi-Desert Med. Center v. Douglas*, & *Modoc Med. Center v. Douglas*). In the fourth case, the superior court granted the writ petition and the Department has appealed. (*George L. Mee Mem'l Hosp. v. Douglas*).

To date, no court has ruled on SB 1103's substantive validity.

~~24. *California Association for Health Services At Home, et al., v. Sandra Shewry*~~

~~Plaintiffs (an association of home health care providers, a home health care provider, and a disability rights advocacy group) filed a lawsuit on April 27, 2004 seeking reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement; the Medicaid Act's "access" and efficiency, economy, and quality of care ("EEQ") provisions; federal regulation (42 C.F.R. § 447.204) and the State Plan.~~

~~In March 2007, following an appeal of a trial court decision, the Court of Appeal issued a published decision holding that:~~

- ~~The Department was required to review reimbursement rates for home health services annually for years 2001 through 2005 to ensure that they comply with the former State Plan provision incorporating 42 U.S.C. 1396a(a)(30)(A), and~~
- ~~The Department was not obligated to set new rates – i.e., for years after 2005.~~

~~Following the appellate decision, the Department completed a rate review and concluded that rates paid to home health care providers for 2001-2005 were consistent with section~~

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~~1396a(a)(30)(A). After the rate review was filed with the trial court, plaintiffs objected. On September 25, 2009, the trial court held that the Department did not perform a proper rate review in light of the standard set forth in *Orthopaedic Hospital v. Belshe*. The court ordered the Department to perform a further rate review.~~

~~The Department appealed the trial court's ruling. On March 26, 2012, the appellate court issued a published decision, affirming in part and reversing in part, holding:~~

- ~~The Department was not required to consider provider costs under section 30(A) when performing the rate review,~~
- ~~Section 30(A)'s requirement of "efficiency" and "economy" did not impose a minimum limit for,~~
  ~~Medi-Cal reimbursement rates,~~
- ~~Lack of complaints was sufficient to establish quality of care under section 30(A), and~~
- ~~There was insufficient evidence to support the Department's finding that access to home health care services during the period 2001-2005 complied with section 30(A).~~

~~The case was remanded to the trial court, which issued an order on October 29, 2012, requiring the Department to conduct a further rate review for 2001-2005 for the purpose of further evaluating whether rates were sufficient for beneficiaries to have adequate access consistent with the March 2012 Court of Appeal decision. In March 2013, the Department completed a further rate review, in which it determined that the rates paid to HHAs during 2001-2005 were sufficient to comply with the Access requirement of federal Medicaid law. The plaintiffs have filed a motion challenging the validity of the Department's further rate review. They seek a court order to invalidate the rates and to require the Department to pay HHAs damages for the period since 2001 equal to the difference between the rates paid and each HHA's usual and customary changes. There was a court hearing on the plaintiffs' motion on December 13, 2013.~~

~~On January 29, 2014, the trial court issued a decision in favor of the Department. The court ruled that the Department had reasonably determined based on its rate review that Medi-Cal beneficiaries had sufficient access to HHA services during 2001-2005 consistent with federal law.~~

24. *California Hospital Association v. Shewry*

The California Hospital Association (Plaintiff) is a trade association representing nursing facilities that are a distinct part of a hospital (DP/NFs). Plaintiff contends the Department's policy of excluding the projected costs of facilities with less than 20% Medi-Cal days in determining the median rate results in rates that violate various laws, including 42 U.S.C. section 1396a(a)(30)(A). Plaintiff also contends that the freeze in rates during rate year 2004-05 violated section 1396a(a)(30)(A). Plaintiff seeks an injunction against the continued use of the 20% exclusion policy and a writ of mandate requiring the Department to recalculate rates for rate years 2001-02 to present and pay DP/NFs the additional amount owed based on the recalculations.

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On August 20, 2010, the Court of Appeal issued a decision reversing the trial court's judgment in favor of the Department. The Court of Appeal held that the Department violated section 1396a(a)(30)(A) by failing to evaluate whether rates were reasonable relative to provider costs. The case has been remanded back to the trial court for further litigation concerning the plaintiff's challenge to the rates paid for rate years 2001-02 to present. So far, there has been some additional discovery, but no other activity has occurred since the remand.

25. *Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services*

Plaintiffs are 17 hospitals that contend that the 10% Medi-Cal payment reductions the Department implemented for non-contract hospital inpatient services, pursuant to ABX4 5 (Chapter 3, Statutes of 2008), violate various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(8) and 1396a(a)(30). The status of the case is as follows:

- On November 18, 2009, the district court issued a preliminary injunction with respect to the 10% payment reduction for non-contract hospital inpatient services rendered on or after that date with respect to only the 17 plaintiff hospitals,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,
- On February 22, 2012, the United States Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case back to the Ninth Circuit to reconsider the Department's appeal of the preliminary injunction, and
- On January 9, 2014, the Ninth Circuit issued a decision reversing and vacating the November 2009 injunction and remanded to the district court for further proceedings.

26. *Independent Living Center of Southern California Inc. et al. v. David Maxwell-Jolly*

This lawsuit challenges the 10% reduction required by AB 5 (Chapter 3, Statutes of 2008) in Medi-Cal payments that took effect on July 1, 2008. These reductions are mandated by W&I Code sections 14105.19 and 14166.245. Plaintiffs contend that these reductions violate 42 U.S.C. section 1396a(a)(30)(A) and the Americans with Disabilities Act. The status of this case is as follows:

- On August 18, 2008, the district court issued a preliminary injunction against the 10% reduction for physicians, dentists, optometrists, adult day health care centers, clinics, and for prescription drugs for services on or after August 18, 2008,
- On November 17, 2008, the district court issued a preliminary injunction against the 10% reduction for home health and non-emergency medical transportation (NEMT) services for services on or after November 17, 2008,
- On July 9, 2009, the Ninth Circuit issued a decision affirming the district court's August 18, 2008, preliminary injunction. The Ninth Circuit further granted plaintiffs' appeal with respect to their claim that the district court's August 18, 2008, injunction should have applied to service back to July 1, 2008,
- On August 7, 2009, the Ninth Circuit issued a decision affirming the district court's preliminary injunction with respect to NEMT and home health services,

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- On January 22, 2010, the district court issued an order requiring the Department to pay additional money due for July 1, 2008 through August 17, 2008 to providers in the 6 categories covered by the August 18, 2008 injunction,
- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case to the Ninth Circuit to reconsider the Department's appeals of the two injunctions. Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government.

27. <u>AB 1183 Litigation</u>

Two lawsuits challenged provider payment reductions that were mandated by AB 1183 (Chapter 758, Statutes of 2008) effective October 1, 2008 for non-contract hospital inpatient services, and March 1, 2009 for prescription drugs, adult day health care center (ADHC) services, and other hospital services. The plaintiffs in these cases contend that the reductions violate 42 US Code Section 1396(a)(30)(A).

- In the *Independent Living Center of Southern California* (formerly *Managed Care Pharmacy*) *v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on February 26, 2009 against the 5% payment reduction for prescription drugs.

- In the *California Pharmacists Association, et al. v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on March 6, 2009 against the 5% payment reduction for ADHC services. The district court denied a preliminary injunction against the AB 1183 payment reductions for hospitals. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit granted the plaintiffs' motion for a stay of the district court's denial of a preliminary injunction concerning the hospital payment reductions, pending their appeal of that ruling, which effectively enjoined the AB 1183 payment reductions for hospitals beginning April 6, 2009.

On March 3, 2010, the Ninth Circuit issued three decisions that affirmed preliminary injunctions against the AB 1183 payment reductions for prescription drugs, ADHC and hospital services. On February 22, 2012, the Supreme Court issued a ruling that vacated the Ninth Circuit decisions and remanded both cases back to the Ninth Circuit to reconsider the Department's appeals of the three injunctions in the above cases. Further appellate

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briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government.

28. AB 97 Litigation

~~Four~~ **Five** lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.

- *California Hospital Association v. Douglas, et al.*

  Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011 shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government (Secretary of the Department of Health and Human Services, Kathleen Sebelius), which approved a State Plan Amendment (SPA) concerning these reductions, was been named as a co-defendant.

  On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011 that were not reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions (also rate freeze with respect to the *California Hospital Association* case), as described in the 10% Payment Reduction for LTC Facilities and Non-AB 1629 LTC Rate Freeze policy changes. **The lawsuit has been remanded to the federal district court where plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments for DP/NFs.**

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- *Managed Pharmacy Care, et al. v. Sebelius, et al.*

  Plaintiffs, a Medi-Cal beneficiary, five pharmacies, a statewide pharmacy member group, an independent living center, and the state association of independent living centers, challenge the October 27, 2011 action of defendant Secretary of the U.S. Department of Health and Human Services (HHS), approving a SPA of defendant California Department of Health Care Services for a 10% Medi-Cal payment reduction. Plaintiffs allege that Medi-Cal payment reductions mandated by AB 97 (as amended by AB 102) violate requirements set forth in 42 U.S.C. section 1396a(a)(30)(A), and that HHS violated the Federal Administrative Procedure Act in approving the SPA. Plaintiffs also allege violation of the due process clause of the 14th Amendment, the Fifth Amendment, and the Privileges and Immunities Clause of the U.S. Constitution.

  On December 28, 2011, the district court issued a preliminary injunction against the 10% reduction for prescription drugs. On March 12, 2012, the district court issued an order modifying the preliminary injunction to allow the Department to apply the payment reduction for prescription drugs provided to services rendered from June 1, 2011 through December 27, 2011 that are reimbursed for the first time on or after December 28, 2011. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy change. **Plaintiffs in this case have filed a dismissal of their lawsuit.**

- *California Medical Transportation Association v. Douglas, et al.*

  Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.

  On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the

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four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. **This case has been remanded to the federal district court where the plaintiffs have indicated they intend to pursue a new court order that would prohibit the Department from implementing the AB 97 payment reductions for NEMT services.**

- *California Medical Association et al. v. Douglas,*

  Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government (Kathleen Sebelius, Secretary of Health and Human Services), which recently approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

  On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012 that are not reimbursed at the unreduced rates prior to that date. The Department appealed, and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. On January 13, 2014, the United States Supreme Court denied the plaintiffs' petition for certiorari asking it to review the Ninth Circuit decision. Now that the injunction is vacated, the Department will implement the AB 97 payment reductions, as described in the 10% Provider Payment Reduction policy changes. **This case has been remanded to the federal district court where the plaintiffs have indicated they intend to seek a new court order prohibiting the Department from implementing the AB 97 reduced payments.**

- ***Eastern Plumas Healthcare District, et al. v. Dept. of Health Care Services, et al.***

  Plaintiffs are nine hospitals that operate nursing facilities that are a distinct part of a hospital (DP/NFs). This lawsuit was filed May 2014 in San Francisco Superior Court to challenge the validity of the AB 97 reduced rates for DP/NFs that are to be implemented for the period June 1, 2011 through September 30, 2013 pursuant to the federally approved State Plan.

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29. *California Hospital Association v. David Maxwell-Jolly*

This lawsuit seeks to enjoin a "freeze" in rates for the 2009-10 rate year (i.e. freeze rates at the 2008-09 rate levels) for hospital based nursing facility and sub-acute care services and the extension to some small and rural hospitals of the 10% reduction for non-contract hospital inpatient services. Plaintiff alleges violations of various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30), and that implementation of these statutory changes is preempted by the Supremacy clause of the United States Constitution.

On February 24, 2010, the district court issued a preliminary injunction against the 10% reduction for small and rural hospitals and the freeze in rates for hospital based nursing facility and sub-acute services. On appeal, the Ninth Circuit granted the Department's motion for a stay of appellate proceedings pending petitions for certiorari in Maxwell-Jolly v, Independent Living Centers and Maxwell-Jolly v. California Pharmacists Association. On March 30, 2012, the Ninth Circuit ordered an end to the stay. This case has been referred to non-binding mediation in the Ninth Circuit, so there will be no further briefs submitted by the parties until the mediation is complete.

Further appellate briefing in the Ninth Circuit was stayed pending Ninth Circuit mediation, in which the parties have now reached a global settlement agreement involving this case and several other lawsuits, challenging payment reductions under AB 5 (Chapter 3, statutes of 2008), AB 1183 (chapter, 758, statutes of 2008), and AB 5, Chapter 5, Statutes of 2009). Under the terms of the global settlement, DHCS agrees not to recoup money from providers related to payment reductions in this case and the others that were enjoined, but later federally approved for some periods. In exchange, the plaintiffs will dismiss several state court lawsuits, in which the potential fiscal exposure for the State is four times the amount of money DHCS will not be recouping. The terms of the settlement are subject to approval by the federal government.

30. ABX3 5 Litigation

- *California Association of Rural Health Clinics, et al. v. Maxwell-Jolly*

  Plaintiffs, an individual Federally Qualified Health Center (FQHC) and an association representing multiple Rural Health Clinics (RHCs), allege that the Department illegally applied the 2009 elimination of certain optional Medi-Cal benefits required by ABX3 5 (Chapter 20, Statutes of 2009) to FQHCs and RHCs. Plaintiffs contend that certain benefits are mandatory when provided by an FQHC and seek to compel the Department to continue to reimburse FQHCs for these services. Plaintiffs contend that W&I Code section 14131.10 is preempted via the Supremacy Clause of the US Constitution as to Departmental payment to FQHCs and RHCs for the provision of these eliminated benefits.

  On October 20, 2010, the district court issued an order enjoining the Department from disallowing certain optional benefits to RHCs and FQHCs until the applicable

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SPA was approved by CMS. Both the Department and Plaintiffs appealed. On May 23, 2011, CMS approved the SPA eliminating the Medi-Cal optional benefits for all providers, including FQHCs and RHCs.

On July 5, 2013, the Ninth Circuit Court of Appeals found that the statutory definition of physician services for FQHCs and RHCs includes the eliminated services. Although these services are optional under Medi-Cal, in FQHCs and RHCs, they are mandatory and Medi-Cal must reimburse for them. The Ninth Circuit further found that the Department was obligated to obtain SPA approval before implementing it. This ruling became effective on September 26, 2013. Accordingly, beginning September 26, 2013, the Department ~~must reimburse~~ **began reimbursing** FQHCs and RHCs for podiatry, optometry and chiropractic services. **The parties are currently litigating the form of the judgment.**

- ***American Indian Health Services, Inc., et al. v. Toby Douglas, et al.***

  Petitioners and plaintiffs, which are Federally Qualified Health Centers (FQHC), filed a Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief. Petitioners and plaintiffs seek an order requiring the Department to process and pay claims for adult dental, podiatry, and chiropractic services that petitioners provided to eligible Medi-Cal beneficiaries during the period July 1, 2009 to September 26, 2013 pursuant to 42 U.S.C. sections 1396a(a)(10)(A), 1396d(l)(1) and (20), 1395x(aa)(1)(A) and 1395x(r), and the Ninth Circuit decision in *California Association of Rural Health Clinics, et al v. Douglas* (9th Cir. 2013) 738 F.3d 1007.

31. Managed Care Potential Legal Damages

Four health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate-setting methodology for ~~the~~ rate years ~~from~~ 2002 through 2005. The cases are referred to as:

- *Santa Clara County Health Authority dba Santa Clara Family Health Plan v. DHCS*
- *Health Net of California, Inc. v. DHCS*
- *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
- *Molina Healthcare of California, Inc., v. DHCS*

On April 20, 2011, the trial court issued a judgment in favor of plaintiff Santa Clara County Health Authority and on June 13, 2011, judgment was issued in favor of plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit. Similarly, the Department has entered into settlement agreements with Blue Cross and Molina in mid/late 2013. The Department ~~is in the process of finalizing the settlement agreement in the Santa Clara litigation.~~ **and Santa Clara have also entered into a settlement agreement.**

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The Department is also currently in the process of settling a similar rates dispute with Medi-Cal Managed Care Plan Inland Empire Health Plan (IEHP). This case is currently pending before the Office of Administrative Hearings and Appeals and settlement discussions are on-going.

32. *AIDS Healthcare dba Positive Healthcare*

Plaintiff seeks declaratory and injunctive relief to prohibit the Department from complying with W&I Code section 14105.46. The complaint alleges that section 14105.46 violates State and federal law, because that State statute illegally compels AIDS Healthcare Foundation (AHF) to accept payment under the methodology set forth in the federal 340B program for the drugs it provides to persons with HIV and AIDS.

As a result of a Motion to Dismiss filed by the Department, on March 15, 2010, the court dismissed this case in its entirety, with prejudice. Plaintiff appealed. On November 3, 2011, the Ninth Circuit Court of Appeals issued an unpublished decision affirming in part and reversing in part the lower court's dismissal of the case. Plaintiff's claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA proceeded. In October 2012, the U.S. District Court stayed this case pending a ruling in the AB 97 consolidated appeal. On December 13, 2012, the Ninth Circuit Court of Appeal issued a decision in the AB 97 consolidated cases. The Department filed a motion to continue the stay, but on February 25, 2013, the court lifted the stay.

After the stay was lifted, the parties filed cross-motions for summary judgment. On March 18, 2013, the court found in favor of the Department on the Equal Protection claims, but ruled in favor of Plaintiff on their cross-motion for summary judgment on the (a)(30)(A) and SPA approval causes of action. The court held that:

- The Department was required to obtain SPA approval prior to implementation and did not do so, and
- Neither the legislature nor the Department considered the relevant factors under (a)(30)(A). The court enjoined the Department from implementing the 340B drug program, effective May 3, 2013.

~~The Department has filed a Notice of Appeal with the Ninth Circuit Court of Appeals.~~ **The Department submitted the SPA on November 1, 2013. CMS approved the SPA on January 30, 2014. Following DHCS' motion the Ninth Circuit vacated the judgment and remanded to the district court to consider the impact of CMS' approval. At the June 18, 2014 hearing on the mandate of the Ninth Circuit Vacating and Remanding, the district court changed the findings of fact to reflect the SPA approval, but re-issued the permanent injunction. DHCS plans to appeal to the Ninth Circuit.**

33. *Darling et al. v. Toby Douglas*

This lawsuit sought to enjoin the elimination of Medi-Cal coverage of adult day health care (ADHC) services, as required by AB 97 (Chapter 3, Statutes of 2011). Plaintiffs contend that elimination of Medi-Cal covered ADHC services violates various federal laws, including the

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Americans with Disabilities Act. The Department and plaintiffs entered into a settlement agreement, which was approved by the court in January 2012. The settlement ended ADHC services effective March 31, 2012, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective April 1, 2012. The settlement agreement ~~will be~~ **was** in effect until August 31, 2014~~, with the court retaining jurisdiction during the pendency of the settlement~~.

34. *California Association of Health Facilities, et al. v. Toby Douglas*

This lawsuit seeks to enjoin a freeze in the Medi-Cal rates paid to intermediate care facilities for the developmentally disabled (ICF/DDs), including ICF/DD-Hs (habilitative) and ICF/DD-Ns (Nursing), and freestanding pediatric sub-acute care facilities (W&I Code section 14105.191 (f)(2)). Plaintiffs contend that the state violated 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30)(A) in enacting and implementing the rate freeze, and that the freeze statute is therefore preempted by federal law under the supremacy clause of the United States Constitution. The status of the case is as follows:

- On May 6, 2011, the court issued a preliminary injunction against the rate freeze,
- On June 28, 2011, the United States Court of Appeals (Ninth Circuit) granted the Department request for a stay of the preliminary injunction pending appeal,
- On November 30, 2011, the Ninth Circuit issued a decision reversing the preliminary injunction, and
- On March 21, 2012, the district court granted plaintiffs' motion for leave to amend their complaint to state a claim under the "takings" clause of the Constitution, and to name HHS Secretary Sebelius as a defendant. The district court stayed further litigation pending a decision by the Ninth Circuit on remand in the Independent Living litigation.
- **On June 10, 2014, the federal court dismissed the plaintiffs' lawsuit with prejudice, pursuant to joint stipulation of the parties.**

35. *California Pharmacists Association v. David Maxwell-Jolly*

This lawsuit challenges the legality of a new upper billing limit provision concerning maximum allowable ingredient costs (MAICs) and the use of recently reduced average wholesale prices (AWPs) in reimbursing drugs. Plaintiffs claim that the State has not complied with 42 U.S.C. section 1396a(a)(30)(A) in enacting and implementing these changes.

On May 5, 2010, the district court issued an order granting preliminary injunction concerning the new upper billing limit and new MAICs, but denying preliminary injunction concerning the AWP reductions. The Department and plaintiff both appealed. On April 2, 2012, the Ninth Circuit lifted a stay of the appellate litigation that had been in effect. The preliminary injunction remains in effect. The Ninth Circuit has postponed appellate court briefing to allow the parties time to first explore possible settlement.

36. *Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly*

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This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The third cause of action (duty to review rates annually) was transferred to a different judge to be heard separately from the other two causes of action. Based on the hearing on the third cause of action, the Court ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. The Rate Review was filed with the court on December 16, 2011. On March 15, 2012, the court ordered the parties to proceed on the two remaining causes of action. On April 30, 2012, the Department filed a demurrer to the (a)(30)(A) cause of action. The hearing on the demurrer was held on June 28, 2012, and the demurrer was sustained without leave to amend, which disposed of the second cause of action. Petitioners then dismissed their equal protection claim.

On May 23, 2013, Petitioners moved to enforce the writ, claiming that the Department's rate review was inadequate. At a hearing on June 21, 2013, the Court found that the Department's rate review was generally adequate, but had failed to adequately compare Medi-Cal's rates to those of other third party payers, as required by the statute. **The Department is currently in the process of securing rate information from other third party payors to conduct this comparison.** The Court set a hearing for ~~February 14, 2014~~ **September 19, 2014,** at which the Department must either submit a revised annual report **with the third party payors' information,** or show cause why it should be excused from doing so.

37. Family Planning Services – Los Angeles County Claims Reviewed by the OIG

The Office of the Inspector General (OIG) plans to conduct an audit of family planning services claimed under the Family PACT program in Los Angeles County. The audit will determine whether the Department complied with Federal and State requirements when claiming Federal reimbursement at the 90% rate for family planning services provided under the Family PACT program. The audit period covers payments made during the period October 1, 2010 through September 30, 2011.

38. *Marquez v. California Department of Health Care Services, David Maxwell-Jolly* Lawsuit

~~In this pending litigation, the petitioners seek~~ **Petitioners sought** a writ of mandate that would ~~require~~ **have required** the Department to provide a Medi-Cal beneficiary with a due process notice (Notice of Action) and the right to appeal (Fair Hearing) when other health coverage (OHC) is added to a Medi-Cal beneficiary's record. Alternatively, petitioners ~~contend~~ **contended** that the Medi-Cal program should change from a cost-avoidance

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system to a "pay and chase" recovery process. The ~~writ of mandate~~ **petition** was denied, and ~~the~~ petitioners have ~~filed a notice of appeal.~~ **appealed.**

39. *Saavedra, et al. v. Toby Douglas, California Department of Health Services Lawsuit*

In this writ litigation, petitioners allege that the Department improperly transitioned Seniors and Persons with Disabilities from the fee-for-service Medi-Cal delivery system into the managed care Medi-Cal delivery system by failing to appropriately respond to and process beneficiary requests to be exempted from the transition to managed care ("medical exemption requests"). Petitioners assert that the Department is applying improper standards in deciding medical exemption requests. ~~The writ petition is scheduled for hearing on June 24, 2014.~~ **The Department has revised the denial letter, denial codes and the regulation governing medical exemption requests and is resuming settlement discussions with Petitioners' counsel. If the parties are unable to agree to a settlement, the writ petition is scheduled for hearing on December 4, 2014.**

40. *Farrow v. Toby Douglas, Director of DHCS, et al.*

Petitioner is a disabled Medi-Cal beneficiary whose services were reduced when he reached the age of twenty-one (21). Petitioner alleges that the Department failed to provide petitioner with medically necessary in-home nursing services to which he was entitled under the Medi-Cal program, thereby placing him at risk of institutionalization in violation of state and federal anti-discrimination laws. Petitioner also alleges that the Department failed to comply with statutory and Constitutional due process requirements, including timely notice of termination of benefits, a pre-termination hearing, and aid pending a hearing decision. In addition, petitioner contends that the Department denied him a fair administrative hearing. **No hearing has been scheduled.**

41. T. Michael, LLC v. Toby Douglas, Director of DHCS

Plaintiff, on its own behalf and as a class action representative for Residential Care Facilities for the Elderly (RCFEs), challenges the Department's implementation of the 10% payment reductions enacted pursuant to Assembly Bill (AB) 97 (Statutes of 2011) on services provided under the Assisted Living Waiver (ALW).

In April 2013, the Department, pending waiver amendments, reversed its decision to implement the AB 97 reductions on RCFEs and services provided under the ALW. In May 2013, the Department instructed its contractor-agent to process the Erroneous Payment Corrections (EPCs) retroactive to June 2011. The Department's contractor-agent failed to process the EPCs within the required contractual deadline of 120 days.

In April 2014, plaintiff filed a state class action lawsuit and seeks to: (1) have the EPCs processed within 10 days; (2) receive interest; (3) attorneys' fees.

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As of May 2014, the Department processed and paid the EPC for the entire RCFEs class. Parties are disputing interest and attorneys' fees.

42. *Asante, et al. v. Department of Health Care Services, et al.*

Plaintiffs are 18 out-of-state hospitals that challenge the validity of Medi-Cal reimbursement paid to out-of-state hospitals for hospital inpatient services. They filed this lawsuit in June 2014 in San Francisco Superior Court. Plaintiffs contend that aspects of the new diagnosis-related group (DRG) reimbursement policy discriminate against out-of-state hospitals in violation of the Interstate Commerce clause and Equal Protection clause of the United States Constitution. They further contend that the Department is violating federal Medicaid law by not making disproportionate share hospital (DSH) payments to qualifying out-of-state hospitals.

43. *Riverside Recovery Resources v. Riverside County Department of Mental Health, et al.*

Plaintiff Riverside Recovery Resources filed a complaint April 10, 2014 in Riverside County Superior Court against Riverside County Department of Mental Health and the State of California contesting disallowances of monies for Drug-Medi-Cal services provided to minors in Riverside County schools. The listed cause of actions stated include Writ of Administrative Mandamus and Breach of Contract related to disallowances stemming from a Department/DMC audit that found services were claimed for duration of time in which Riverside Recovery Resources was not lawfully certified for reimbursement. As a result, Riverside County has withheld reimbursement for services during the period of time Riverside Recovery Resources was found to be in non-compliance. Plaintiff disputes the facts upon which the non-compliance findings were based, and denial of due process in the administrative appeal process. A status conference is set for July 24, 2014. The Department has not been served with the current complaint.

44. *Westside Center for Independent Living, et al v. DHCS*

On July 2, 2014, seven petitioners filed a lawsuit in state court against the Department and its director asking the court to enjoin the implementation of the Coordinated Care Initiative (CCI) and to disenroll beneficiaries currently enrolled in CCI. CCI is a joint CMS/Department project seeking to coordinate care for dual eligible beneficiaries. Petitioners allege that the Department was without authority to implement CCI and violated certain statutory provisions and due process by failing to comply with necessary notice requirements. On July 11, 2014, the court denied petitioners' ex parte application for a temporary restraining order. The court continued the matter for hearing until August 1, 2014, to decide whether the court should enjoin CCI pending a hearing on the merits. On August 1, 2014, the court denied petitioners' motion for preliminary injunction. Petitioners will likely appeal.

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45. *Placentia-Linda Hospital, et al.* v. *California Department of Health Care Services*

The lawsuit was filed in San Francisco County Superior Court on April 9, 2014. Plaintiffs are five hospitals that contend that the Department implemented Medi-Cal payment reductions for non-contract hospital inpatient services from July 1, 2008 through April 12, 2011, as required by Assembly Bill 5 (statutes 2008) and Assembly Bill 1183 (statutes 2008), in violation of 42 United States Code sections 1396a(a)(13) and 1396a(a)(30)(A). Plaintiffs seek a court order requiring the Department to retroactively pay them the additional money they would have received if the Department had not implemented the reductions.

OTHER: REIMBURSEMENTS

46. Federal Upper Payment Limit

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

The UPL only applies to private hospitals and non-designated public hospitals that are part of the category of “non-state government-owned hospitals”. The UPL for designated public hospitals consists of audited costs.

47. Accrual Costs Under Generally Accepted Accounting Principles

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state’s fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to accrual. For the most recently completed fiscal year (FY 2012-13), the June 30, 2013 Medi-Cal accrual amounts were estimated to be $2.23 billion state General Fund, $5.09 billion federal funds, and $1.47 billion special fund, for a total of $8.79 billion.

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48. Freestanding Clinic – Former Agnews State Hospital

The 2003-04 Governor's Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

The Department has obtained approval from CMS to amend the State Plan to establish a cost-based reimbursement methodology for the freestanding clinic beginning April 1, 2009.

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

49. Refund of Recovery

CMS requested the Department prepare reconciliations of Grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of $240 million FFP for federal FY 2007 through 2011 and $34 million FFP ongoing each month.

OTHER: RECOVERIES

49. Recovery of PCS/IHSS

SB 412 (Chapter 548, Statutes of 1995) permits the Department to seek estate recovery (ER) against the estate of the decedent, or any recipient of the property of the decedent, for health care services received. The Department ~~proposed~~ **will propose** regulations to include Personal Care Services (PCS), a service offered under the In-Home Supportive Services (IHSS) program, in ER claims. The addition of PCS is expected to increase savings for the Department**.**~~, however, the draft regulations are still under Departmental review~~.

50. Additional Personal Injury Recoveries

In *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, the United States Supreme Court held that a Medicaid agency's lien recovery from a Medicaid beneficiary's tort settlement is limited to the portion of the settlement that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary. Then,

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in *Wos v. E.M.A.* (2013) 133 S.Ct. 1391, the U.S. Supreme Court held that states may not adopt a one-size-fits-all mechanism for allocating medical expenses, such as deeming a specific percentage of a tort settlement or award to be the medical expenses portion. Instead, states must have processes for determining and recovering only that portion that is attributable to medical expenses.

In response to the *Ahlborn* ruling, California amended Welfare & Institutions (W&I) Code Section 14124.76 and enacted W&I Code Section 14124.785.

On December 26, 2013, H.J. Res. 59 (federal Budget Act) was signed into law. Section 202 of the Act addresses Medicaid third party liability. Section 202, effective October 1, 2014, essentially supersedes *Ahlborn* and *Wos* by allowing states to recover from the full amount of a beneficiary's tort settlement, instead of only the portion designated for medical expenses. The implementation date has been delayed to October 1, 2016. The nullification of the *Ahlborn* ruling is expected to increase savings for the Department.

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

51. Dental Program Utilization Controls Assessment

In an effort to improve the provider experience and to encourage further provider participation, the Department is evaluating program utilization controls and other administrative requirements to make the program more provider friendly while maintaining program integrity. The results of this effort are anticipated to be increased provider participation and potentially increased beneficiary utilization.

~~52. Enroll Registered Dental Hygienist as Billing Providers~~

~~The Department anticipates allowing the enrollment of Registered Dental Hygienists (RDH) who provide preventive dental services in public health programs as Denti-Cal billing providers will result in an increase in the following areas: access to care, utilization, and the Denti-Cal provider network. As outlined in the Medicaid Oral Health Learning Collaborative, it is California's goal to increase by 10 percentage points the proportion of children enrolled in Medicaid ages 1-20 years who receive a preventive dental service over a five-year period. This policy change would help California move toward achieving that goal.~~

53. Teledentistry

The Department considers Teledentistry a cost-effective alternative to dental services provided in-person, predominantly in underserved areas. Teledentistry is a way for dentists to deliver services to their patients that is similar to in-person care. The standard of care is the same whether the patient is seen in person or through the Teledentistry environment.

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This method of providing services would allow for improved access to care options for beneficiaries who typically experience access to care issues.

54. Dental Managed Care Experience Based Rates

The rates for the Dental Managed Care plans are currently based on Fee-for-Service program experience. The Dental Managed Care plans believe that the capitation rates they receive do not adequately compensate them for all the duties and benefits they provide. The Department is considering developing a rate setting methodology based on actual plan experience.

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

ELIGIBILITY
PC 15 PARIS Federal
PC 17 PARIS Interstate

AFFORDABLE CARE ACT

BENEFITS
PC 38 Restoration of Select Adult Dental Benefits
PC 42 Dense Breast Notification Supplemental Screening

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH
PC 78 Solano County SMHS Realignment Carve-Out

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 22 Mental Health Services Expansion
PC 142 Discontinue Undocumented Beneficiaries from PHC

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

ELIGIBILITY
CA 8 State Only Former Foster Care Program

AFFORDABLE CARE ACT

BENEFITS
OA 78 FPACT Support, Provider Educ. & Client Outreach

HOME & COMMUNITY-BASED SERVICES
OA 20 ADHC Transition – Administration

BREAST AND CERVICAL CANCER

PHARMACY

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 128 Increase in Capitation Rates for Gross Premium Tax
PC 133 Funding Adjustment of Gross Premium Tax to GF

PROVIDER RATES

SUPPLEMENTAL PAYMENTS
PC 195 Hospital QAF-Children's Health Care

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL
OA 82 Dental FI Re-Procurement IV & V

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY
OA 10 Transition of HFP to Medi-Cal

AFFORDABLE CARE ACT
OA 57 Recovery Audit Contractor Costs
PC 33 ACA Expansion- Pregnancy Only

BENEFITS
OA-24 Restoration of Select Adult Dental Benefits
OA 78 FPACT Support, Provider Edu & Client Outreach
PC 50 Copayment for Non-Emergency ER Visits

HOME & COMMUNITY-BASED SERVICES
PC 141 SCAN Transition to Managed Care
PC 222 PACE Rate Increase

BREAST AND CERVICAL CANCER

PHARMACY
PC 220 State Supplemental Specialty Drug Rebates

DRUG MEDI-CAL

MENTAL HEATLH

1115 WAIVER—MH/UCD & BTR

MANAGED CARE
PC 128 Increase in Cap Rates for Gross Premium Tax
PC 133 Funding Adjustment of Gross Premium Tax to GF
PC 141 – SCAN Transition to Managed Care

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

DISCONTINUED ASSUMPTIONS

Withdrawn

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

ACRONYMS AND ABBREVIATIONS

A

A&I	Audits and Investigations Division
AAC	Average Acquisition Cost
AAP	Adoption Assistance Program
AB	Assembly Bill
ABD	Aged, Blind & Disabled
ACA	Affordable Care Act
ACL	Adjudicated Claim Line
ACMS	Automated Collection Management System
ACS	Affiliated Computer Services
ACSL	Adjudicated Claim Service Line
ACSs/Enh.	Additional Contract Services/Enhancements
ACWDL	All-County Welfare Directors Letter
ADHC	Adult Day Health Care
ADRC	Aging and Disability Resource Connection
AEVS	Automated Eligibility Verification System
AFDC	Aid to Families with Dependent Children
AFLP	Adolescent and Family Life Program
AH	Acute Hospitals
AHF	AIDS Health Care Foundation (aka Positive Healthcare Services)
AI/AN	American Indian/Alaska Native
ALWPP	Assisted Living Waiver Pilot Project
AMP	Average Manufacturer Price
AOO	Assumption of Operations
APD	Advance Planning Document
APS	Adult Protective Services
ARRA	American Recovery and Reinvestment Act of 2009
ASPPP	Adolescent Sibling Pregnancy Prevention Program
AV	Administrative Vendor
AWP	Average Wholesale Price

B

BA	Base Adjustment
BBA	Balanced Budget Act of 1997
BCCTP	Breast and Cervical Cancer Treatment Program
BIC	Benefits Identification Card
BIH	Black Infant Health
BIPA	Benefits Improvement and Protection Act of 2000
BTR	California Bridge to Reform Demonstration
BSA	Bureau of State Audits
BY	Budget Year

C

CA	County Administration
CA-EV/CMS	California Eligibility Verification/Claims Management System
CAHF	California Association of Health Facilities
Cal-COBRA	California Consolidated Omnibus Budget Reconciliation Act
CalHEERS	California Healthcare Eligibility, Enrollment and Retention System

CalWIN	CalWORKS Information Network
CalWORKs	California Work Opportunity and Responsibility to Kids
CA-MMIS	California Medicaid Management Information System
CANHR	California Advocates for Nursing Home Reform
CBRC	Cost-Based Reimbursement Clinic
CCFC	California Children and Families Commission (Proposition 10)
CCAH	Central Coast Alliance for Health
CCM	Coordinated Care Management
CCR	California Code of Regulations
CCS	California Children's Services
CCT	California Community Transitions
CCSAS	California Child Support Automation System
CDA	California Department of Aging
CDADP	California Department of Alcohol and Drug Programs
CDDS	California Department of Developmental Services
CDL	Contract Drug List
CDMH	California Department of Mental Health
CD-MMIS	California Dental Medicaid Management Information System
CDOF	California Department of Finance
CDP	Capital Debt Projects
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CEI	Center for Elders Independence
CESD	Community Elder Care of San Diego
CFCO	Community First Choice Option
CHCF	California Health Care Foundation
CHDP	Child Health and Disability Prevention
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CI	Coverage Initiative (Health Care Coverage Initiative)
CIN	Client Identification Number
C-IV	Consortium IV
CLPP	Childhood Lead Poisoning Prevention
CMAC	California Medical Assistance Commission
CMAS	California Multiple Award Schedule
CMC	Computer Media Claims
CMIPS	Case Management Information and Payroll System
CMS	Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration)
CMS Net	Children's Medical Services Network
CMSB	Children's Medical Services Branch
CMSP	County Medical Services Program
CNI	California Necessities Index
CO	Change Order
COBRA	Consolidated Omnibus Budget Reconciliation Act
COHS	County Organized Health System
COLA	Cost of Living Adjustment
CPE	Certified Public Expenditure
CPI	Consumer Price Index
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CRCS	Cost Reimbursement and Comparison Schedule
CSBG	County Services Block Grant
CTPS	Cigarette and Tobacco Products Surtax (Proposition 99)
CVSO	County Veterans Services Officer

CWD	County Welfare Department
CWDP	California Working Disabled Program
CWS/CMS	Child Welfare Services/Case Management Services
CY	Current Year

D

DAH	Direct Access to Housing
DC	Developmental Center
DHCS	California Department of Health Care Services
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMO	Disease Management Organizations
DOS	Date of Service
DPH	Designated Public Hospital
DP-NF	Distinct Part-Nursing Facility
DRA	Deficit Reduction Act of 2005
DRTS	Drug Rebate Tracking System
DSH	Disproportionate Share Hospitals
DSHP	Designated State Health Program
DSRIP	Delivery System Reform Incentive Pool
DUR	Drug Utilization Review
DY	Demonstration Year

E

EAC	Estimated Acquisition Cost
EDS	Electronic Data Systems
EDU	Encounter Data Unit
EHR	Electronic Health Records
EMBER	Enhanced Medi-Cal Budget Estimate Redesign
EPC	Erroneous Payment Collection
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQROA	Estimated Quarterly Rebate Offset Amount
ES	Eligibility Specialist
ESR	Enrollment Service Representative
ESSP	Emergency Services and Supplemental Payments (Fund)
e-TAR	Electronic Treatment Authorization Request
EW	Eligibility Worker

F

FAME	Fiscal Intermediary Access to Medi-Cal Eligibility
FDA	Food and Drug Administration
FDB	First Data Bank
FFP	Federal Financial Participation
FFS	Fee-for-Service
FI	Fiscal Intermediary
FMAP	Federal Medical Assistance Percentage
FMP	Family Mosaic Project
FOAG	Field Office Automation Group
Family PACT	Family Planning, Access, Care and Treatment
FPL	Federal Poverty Level

FQHC	Federally Qualified Health Center
FS	Free Standing
FSR	Feasibility Study Report
FUL	Federal Upper Limit
FY	Fiscal Year

G

GDB	Genetic Disease Branch
GEMT	Ground Emergency Medical Transportation
GHPP	Genetically Handicapped Persons Program
GMC	Geographic Managed Care
GME	Graduate Medical Education

H

HBEX	Health Benefit Exchange
HCBSW	Home and Community Based Services Waiver
HCCI	Health Care Coverage Initiative
HCERA	Health Care and Education Reconciliation Act of 2010
HCFA	Health Care Financing Administration (now Centers for Medicare and Medicaid Services)
HCO	Health Care Options
HCPCS	Healthcare Common Procedures Coding System
HCSF	Health Care Support Fund
HFP	Healthy Families Program
HHSDC	Health and Human Services Data Center
HICL	Hierarchical Ingredient Code Listing
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPP	Health Insurance Premium Payment
HITECH	Health Information Technology for Economic and Clinical Health
HIT IAPD	Health Information Technology Plan and the Implementation Advanced Planning Document
HIT PAPD	Health Information Technology Planning – Advanced Planning Document
HMO	Health Maintenance Organization
HQARF	Hospital Quality Assurance Revenue Fund
HPSM	Health Plan of San Mateo
HQARF	Hospital Quality Assurance Revenue Fund
HR	House Resolution
H&S	Health and Safety

I

I&E	Information & Education
IA	Interagency Agreement
IAPD	Implementation Advanced Planning Document
ICF-DD	Intermediate Care Facility - Developmentally Disabled
IEVS	Income and Eligibility Verification System
IFB	Invitation for Bid
IGT	Intergovernmental Transfer
IHC	Indian Health Clinic
IHMC	In-Home Medical Care

IHO	In-Home Operations
IHS	Indian Health Services
IHSS	In-Home Supportive Services
IMD	Institutions for Mental Diseases
INS	Immigration and Naturalization Service
INP	Individual Nurse Provider
IOD	Image on Demand
IPO	Independence Plus Option
IPOC	Independent Project Oversight Consultant
IPW	Independence Plus Waiver
IRCA	Immigration Reform and Control Act
ISAWS	Interim Statewide Automated Welfare System
IVR	Interactive Voice Response
IV&V	Independent Verification and Validation

K

KinGAP	Kinship Guardianship Assistance Payment
KT/PT	Kidney Transplant/Pancreas Transplant

L

LAJH	Los Angeles Jewish Homes
LAN/WAN	Local Area Network/Wide Area Network
LDC	Lanterman Developmental Center
LEA	Local Education Agency
LEADER	Los Angeles Eligibility Automated Determination Evaluation and Reporting System
LEC	Local Educational Consortium
LGA	Local Governmental Agency
LI	Local Initiative
LIHP	Low Income Health Program
LIS	Low Income Subsidy
List	List of Contract Drugs (Medi-Cal Drug Formulary)
LOC	Level of Care
LT-AB	Medically Needy Long-Term Care - Blind
LT-ATD	Medically Needy Long-Term Care - Disabled
LTC	Long-Term Care
LTCI	Center for Long-Term Care Integration
LT-OAS	Medically Needy Long-Term Care - Aged

M

MAA	Medi-Cal Administrative Activities
MAC	Maximum Acquisition Cost
MAGI	Modified Adjusted Gross Income
MAGIC	Merced Automated Global Information Control
MAIC	Maximum Allowable Ingredient Cost
MA/SNP	Medical Advantage/Special Needs Program
MAXSTAR	Maximus' proprietary case management software
MCE	Medicaid Coverage Expansion
MCHIP	Medicaid Children's Health Insurance Program
MCM	Medical Case Management
MCO	Managed Care Organization

MEBIL	Medi-Cal Eligibility Information Letter
MEDS	Medi-Cal Eligibility Data System
MEI	Medicare Economic Index
MESH	Medi-Cal Extra-Net for Statewide Health Care
MFP	Money Follows the Person
MHP	Mental Health Plan
MH/UCD	Medi-Cal Hospital/Uninsured Care Demonstration
MI-ADULT	Medically Indigent Adult
MI-CHILD	Medically Indigent Child
MIP	Male Involvement Program
MIPA	Medi-Cal Inpatient Payment Adjustment
MIPPA	Medicare Improvement for Patients and Providers Act
MIS/DSS	Management Information System and Decision Support System
MITA	Medicaid Information Technology Architecture
MLRC	Multi-Level Retirement Community
MMA	The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Medicare Modernization Act)
MMCD	Medi-Cal Managed Care Division
MN	Medically Needy
MN-AB	Medically Needy - Blind
MN-AFDC	Medically Needy - Families
MN-ATD	Medically Needy - Disabled
MN-OAS	Medically Needy - Aged
MOA	Memorandum of Agreement
MOE	Maintenance of Effort
MRMIB	Managed Risk Medical Insurance Board
MSRP	Manufacturer Suggested Retail Price
MSSP	Multipurpose Senior Services Program
MTP	Manual Transformation Program

N

NDC	National Drug Code
NDPH	Non-Designated Public Hospital
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NF-A	Nursing Facility - Level A
NF-B	Nursing Facility - Level B
NF/AH	Nursing Facility/Acute Hospital
NLDC	No Longer Disabled Children
NOA	Notice of Action
NPP	Notice of Privacy Practices
NPRM	Notice of Proposed Rule Making

O

OA	Other Administration
OBRA	Omnibus Budget Reconciliation Act
OCS	Optional Contractual Service
OHC	Other Health Coverage
OIG	Office of the Inspector General
OIL	Operating Instruction Letter
OMDS	Office of Medi-Cal Dental Services

OO	Object Oriented
OSI	Office of System Integration
OTC	Over-the-Counter
OTLICP	Optional Targeted Low-Income Children's Program
OTROS	Office of Technology Review, Oversight and Security

P

PA-AB	SSI/SSP Cash Grant - Blind
PA-AFDC	CalWORKs or Foster Care Cash Grant
PA-ATD	SSI/SSP Cash Grant - Disabled
PACE	Program of All-Inclusive Care for the Elderly
PAN	Payment Action Notice
PA-OAS	SSSI/SSP Cash Grant – Aged
PARIS	Public Assistance Reporting and Information Systems
PASARR	Preadmission Screening and Annual Resident Review
PBM	Pharmacy Benefit Manager
PC	Policy Change
PCAB	Proposed County Administrative Budget
PCCM	Primary Care Case Management
PCES	Paid Claims and Encounters Standardization
PCG	Prenatal Care Guidance
PCSP	Personal Care Services Program
PE	Presumptive Eligibility
PERM	Payment Error Rate Measurement
PFSW	Patient Financial Services Worker
PHC	Partnership HealthPlan of California
PHMS	Public Health Monitoring System
PHP	Prepaid Health Plan
PIA	Prison Industry Authority
PIER	Post Implementation Evaluation Report
P.L.	Public Law
PMPM	Per Member Per Month
POE	Perinatal Outreach and Education
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act of 2010
PPC	Pediatric Palliative Care
PPI	Proton Pump Inhibitor
PPS	Prospective Payment System
Prop. 99	Proposition 99 (Cigarette and Tobacco Products Surtax)
PRUCOL	Permanently Residing (in the United States) Under Color of Law
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
PSD	Payment Systems Division
PSF	Prior Settlement Fund
PTN	Provider Telecommunications Network

Q

QAF	Quality Assurance Fee
QI	Qualifying Individual
QI-1	Qualifying Individual - Program 1
QI-2	Qualifying Individual - Program 2
QIF	Quality Improvement Assessment Fee

QMB	Qualified Medicare Beneficiary
QoL	Quality of Life
QROA	Quarterly Rebate Offset Amount
QSR	Quarterly Status Report

R

RAD	Remittance Advice Detail
RAIS	Rebate Accounting and Information System
REF_NO	Reference Number
RCFE	Residential Care Facilities for the Elderly
RFP	Request for Proposal
RHC	Rural Health Clinic
RMA	Refugee Medical Assistance
ROP	Reasonable Opportunity Period
RPU	Rebate Per Unit
RRP	Refugee Resettlement Program

S

SAVE	Systematic Alien Verification Entitlement
SAWS	Statewide Automated Welfare System
SB	Senate Bill
SBI	Substance Abuse and Brief Intervention
SBRHA	Santa Barbara Regional Health Authority
SCAN	Senior Care Action Network
SCHIP	State Children's Health Insurance Program
SCO	State Controller's Office
SDN	System Development Notice
SDS	Self-Directed Services
SF CLSW	San Francisco Community-Living Support Waiver
SFIS	Statewide Fingerprint Imaging System
SFY	State Fiscal Year
SG	Systems Group
SHMO	Social Health Maintenance Organization
SIR System	Special Incident Reporting System
SLAMSP	South Los Angeles Medical Services Preservation
SLMB	Specified Low-Income Medicare Beneficiary
SMA	Schedule of Maximum Allowances
SMAA	School-Based Medi-Cal Administrative Activities
SMI	Serious Mental Illness
SNCP	Safety Net Care Pool
SNF	Skilled Nursing Facility
SNT	Special Needs Trust
SOC	Share of Cost
SOS	Scope of Services
SOSF	State Operated Small Facility
SOW	Scope of Work
SPA	State Plan Amendment
SPCP	Selective Provider Contracting Program
SPDs	Seniors and Persons with Disabilities
SPE	Single Point of Entry
SPM	Statewide Project Management

SPPCS	State Plan Personal Care Services
SPR	Special Project Report
SRH	Small Rural Hospitals
SRL	Supplemental Report Language
SSA	Social Security Administration
SSI/SSP	Supplemental Security Income/State Supplementary Payment
STI	Sexually Transmitted Infection
STO	State Treasurer's Office
SURGE	Service Utilization Review Guidance and Evaluation
SURS	Surveillance and Utilization Review Subsystem

T

TANF	Temporary Assistance for Needy Families
TAR	Treatment Authorization Request
TBL	Trailer Bill Language
TCM	Targeted Case Management
TCR	Therapeutic Category Review
TIC	Transitional Inpatient Care
TMC	Transitional Medi-Cal
TPL	Third Party Liability
TTG	Toll-Free Telephone Group

U

UBL	Upper Billing Limitation
UCSD	University of California, San Diego
UPL	Upper Payment Limit
UPN	Universal Product Number
USPSTF	United States Preventative Services Task Force

V

VFC	Vaccines for Children Program
VGT	Voluntary Governmental Transfer

W

WAC	Wholesale Acquisition Cost
WCDS	Welfare Client Data System
W&I	Welfare and Institutions
WIC	Women, Infants and Children
WPCS	Waiver Personal Care Services
WRIM	Welfare Reform and Infrastructure Modifications
WSP	Wholesale Sale Price