

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

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>				
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$59,181,000	\$34,578,000	\$24,603,000
5	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$15,844,000	\$10,298,600	\$5,545,400
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$75,025,000</b>	<b>\$44,876,600</b>	<b>\$30,148,400</b>
<b>DRUG MEDI-CAL</b>				
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$31,955,000	\$22,796,000	\$9,159,000
63	NARCOTIC TREATMENT PROGRAM	\$78,650,000	\$78,650,000	\$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$21,243,000	\$21,243,000	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$3,956,000	\$3,956,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$135,804,000</b>	<b>\$126,645,000</b>	<b>\$9,159,000</b>
<b>MENTAL HEALTH</b>				
69	SMHS FOR ADULTS	\$1,025,597,000	\$958,333,000	\$67,264,000
70	SMHS FOR CHILDREN	\$939,189,000	\$899,980,000	\$39,209,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,964,786,000</b>	<b>\$1,858,313,000</b>	<b>\$106,473,000</b>
<b>MANAGED CARE</b>				
109	TWO PLAN MODEL	\$9,744,574,000	\$5,005,989,650	\$4,738,584,350
111	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,567,587,000	\$2,357,380,550	\$2,210,206,450
112	GEOGRAPHIC MANAGED CARE	\$1,862,393,000	\$959,711,850	\$902,681,150
116	REGIONAL MODEL	\$579,530,000	\$299,876,950	\$279,653,050
119	PACE (Other M/C)	\$228,353,000	\$114,176,500	\$114,176,500
120	DENTAL MANAGED CARE (Other M/C)	\$140,401,000	\$82,527,450	\$57,873,550
121	SENIOR CARE ACTION NETWORK (Other M/C)	\$45,628,000	\$22,814,000	\$22,814,000
125	AIDS HEALTHCARE CENTERS (Other M/C)	\$9,338,000	\$4,669,000	\$4,669,000
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$989,000	\$494,500	\$494,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$17,178,793,000</b>	<b>\$8,847,640,450</b>	<b>\$8,331,152,550</b>
<b>OTHER</b>				
167	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,332,570,000	\$2,332,570,000	\$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,583,363,000	\$1,194,363,500	\$1,388,999,500
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,516,618,000	\$0	\$1,516,618,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,362,595,000	\$1,362,595,000	\$0
171	DENTAL SERVICES	\$1,050,674,000	\$644,135,800	\$406,538,200
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$245,500,000	\$245,500,000	\$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$195,908,000	\$195,908,000	\$0
177	MEDI-CAL TCM PROGRAM	\$41,535,000	\$41,535,000	\$0
178	EPSDT SCREENS	\$37,638,000	\$19,272,300	\$18,365,700
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$39,350,000	\$19,675,000	\$19,675,000
183	LAWSUITS/CLAIMS	\$7,921,000	\$3,960,500	\$3,960,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,042,000	\$1,021,000	\$1,021,000

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

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	<b>OTHER</b>			
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,799,000	\$1,799,000	\$0
195	BASE RECOVERIES	-\$297,905,000	-\$147,957,000	-\$149,948,000
	<b>OTHER SUBTOTAL</b>	<b>\$9,119,608,000</b>	<b>\$5,914,378,100</b>	<b>\$3,205,229,900</b>
	<b>GRAND TOTAL</b>	<b>\$28,474,016,000</b>	<b>\$16,791,853,150</b>	<b>\$11,682,162,850</b>

## SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2015-16

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>				
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$93,271,000	\$54,465,000	\$38,806,000
5	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$16,482,000	\$10,713,300	\$5,768,700
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$109,753,000</b>	<b>\$65,178,300</b>	<b>\$44,574,700</b>
<b>DRUG MEDI-CAL</b>				
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$40,057,000	\$27,633,000	\$12,424,000
63	NARCOTIC TREATMENT PROGRAM	\$85,534,000	\$85,534,000	\$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$20,779,000	\$20,779,000	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$47,904,000	\$33,072,000	\$14,832,000
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$194,274,000</b>	<b>\$167,018,000</b>	<b>\$27,256,000</b>
<b>MENTAL HEALTH</b>				
69	SMHS FOR ADULTS	\$1,149,581,000	\$1,080,696,000	\$68,885,000
70	SMHS FOR CHILDREN	\$992,419,000	\$949,324,000	\$43,095,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$2,142,000,000</b>	<b>\$2,030,020,000</b>	<b>\$111,980,000</b>
<b>MANAGED CARE</b>				
109	TWO PLAN MODEL	\$10,518,318,000	\$5,399,004,000	\$5,119,314,000
111	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,589,386,000	\$2,367,680,700	\$2,221,705,300
112	GEOGRAPHIC MANAGED CARE	\$2,050,257,000	\$1,055,369,100	\$994,887,900
116	REGIONAL MODEL	\$750,730,000	\$385,558,450	\$365,171,550
119	PACE (Other M/C)	\$295,935,000	\$147,967,500	\$147,967,500
120	DENTAL MANAGED CARE (Other M/C)	\$146,820,000	\$86,040,300	\$60,779,700
121	SENIOR CARE ACTION NETWORK (Other M/C)	\$47,202,000	\$23,601,000	\$23,601,000
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)	\$976,000	\$488,000	\$488,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$18,406,627,000</b>	<b>\$9,469,210,550</b>	<b>\$8,937,416,450</b>
<b>OTHER</b>				
167	PERSONAL CARE SERVICES (Misc. Svcs.)	\$845,295,000	\$845,295,000	\$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,618,021,000	\$1,209,256,500	\$1,408,764,500
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,636,699,000	\$0	\$1,636,699,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,541,478,000	\$1,541,478,000	\$0
171	DENTAL SERVICES	\$1,101,822,000	\$673,676,500	\$428,145,500
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,500,000	\$206,500,000	\$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$162,286,000	\$162,286,000	\$0
177	MEDI-CAL TCM PROGRAM	\$47,090,000	\$47,090,000	\$0
178	EPSDT SCREENS	\$38,736,000	\$19,834,500	\$18,901,500
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$44,659,000	\$22,329,500	\$22,329,500
183	LAWSUITS/CLAIMS	\$3,690,000	\$1,845,000	\$1,845,000
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,152,000	\$1,076,000	\$1,076,000

**SUMMARY OF BASE POLICY CHANGES  
FISCAL YEAR 2015-16**

<u>POLICY CHG. NO.</u>	<u>CATEGORY &amp; TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	<b>OTHER</b>			
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$1,285,000	\$0
195	BASE RECOVERIES	-\$277,433,000	-\$137,789,000	-\$139,644,000
	<b>OTHER SUBTOTAL</b>	<b>\$7,972,280,000</b>	<b>\$4,594,163,000</b>	<b>\$3,378,117,000</b>
	<b>GRAND TOTAL</b>	<b>\$28,824,934,000</b>	<b>\$16,325,589,850</b>	<b>\$12,499,344,150</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2015 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2014 ESTIMATE  
FISCAL YEAR 2014-15**

NO.	POLICY CHANGE TITLE	2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		MAY 2015 EST. FOR 2014-15		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>											
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPI	\$0	\$0	\$0	\$0	\$59,181,000	\$24,603,000	\$59,181,000	\$24,603,000	\$59,181,000	\$24,603,000
5	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$0	\$0	\$0	\$0	\$15,844,000	\$5,545,400	\$15,844,000	\$5,545,400	\$15,844,000	\$5,545,400
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$75,025,000</b>	<b>\$30,148,400</b>	<b>\$75,025,000</b>	<b>\$30,148,400</b>	<b>\$75,025,000</b>	<b>\$30,148,400</b>
<b>DRUG MEDI-CAL</b>											
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$66,590,000	\$20,321,000	\$80,919,000	\$24,400,000	\$31,955,000	\$9,159,000	-\$34,635,000	-\$11,162,000	-\$48,964,000	-\$15,241,000
63	NARCOTIC TREATMENT PROGRAM	\$24,584,000	\$0	\$72,494,000	\$0	\$78,650,000	\$0	\$54,066,000	\$0	\$6,156,000	\$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$26,379,000	\$0	\$33,512,000	\$0	\$21,243,000	\$0	-\$5,136,000	\$0	-\$12,269,000	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$111,421,000	\$36,914,000	\$5,792,000	\$0	\$3,956,000	\$0	-\$107,465,000	-\$36,914,000	-\$1,836,000	\$0
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-\$27,050,000	\$0	-\$27,850,000	\$0	\$0	\$0	\$27,050,000	\$0	\$27,850,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$201,924,000</b>	<b>\$57,235,000</b>	<b>\$164,867,000</b>	<b>\$24,400,000</b>	<b>\$135,804,000</b>	<b>\$9,159,000</b>	<b>-\$66,120,000</b>	<b>-\$48,076,000</b>	<b>-\$29,063,000</b>	<b>-\$15,241,000</b>
<b>MENTAL HEALTH</b>											
69	SMHS FOR ADULTS	\$565,334,000	\$0	\$1,022,775,000	\$69,364,000	\$1,025,597,000	\$67,264,000	\$460,263,000	\$67,264,000	\$2,822,000	-\$2,100,000
70	SMHS FOR CHILDREN	\$875,642,000	\$0	\$938,451,000	\$36,848,000	\$939,189,000	\$39,209,000	\$63,547,000	\$39,209,000	\$738,000	\$2,361,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,440,976,000</b>	<b>\$0</b>	<b>\$1,961,226,000</b>	<b>\$106,212,000</b>	<b>\$1,964,786,000</b>	<b>\$106,473,000</b>	<b>\$523,810,000</b>	<b>\$106,473,000</b>	<b>\$3,560,000</b>	<b>\$261,000</b>
<b>MANAGED CARE</b>											
109	TWO PLAN MODEL	\$8,792,854,000	\$4,309,888,250	\$9,161,871,000	\$4,415,833,350	\$9,744,574,000	\$4,738,584,350	\$951,720,000	\$428,696,100	\$582,703,000	\$322,751,000
111	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,307,708,000	\$2,112,577,900	\$4,610,126,000	\$2,240,113,750	\$4,567,587,000	\$2,210,206,450	\$259,879,000	\$97,628,550	-\$42,539,000	-\$29,907,300
112	GEOGRAPHIC MANAGED CARE	\$1,619,755,000	\$792,586,600	\$1,769,845,000	\$857,215,100	\$1,862,393,000	\$902,681,150	\$242,638,000	\$110,094,550	\$92,548,000	\$45,466,050
116	REGIONAL MODEL	\$300,253,000	\$145,419,200	\$388,003,000	\$185,242,050	\$579,530,000	\$279,653,050	\$279,277,000	\$134,233,850	\$191,527,000	\$94,411,000
119	PACE (Other M/C)	\$243,791,000	\$121,895,500	\$242,264,000	\$121,132,000	\$228,353,000	\$114,176,500	-\$15,438,000	-\$7,719,000	-\$13,911,000	-\$6,955,500
120	DENTAL MANAGED CARE (Other M/C)	\$67,103,000	\$33,551,500	\$102,736,000	\$51,368,000	\$140,401,000	\$57,873,550	\$73,298,000	\$24,322,050	\$37,665,000	\$6,505,550
121	SENIOR CARE ACTION NETWORK (Other M/C)	\$41,232,000	\$20,616,000	\$44,222,000	\$22,111,000	\$45,628,000	\$22,814,000	\$4,396,000	\$2,198,000	\$1,406,000	\$703,000
125	AIDS HEALTHCARE CENTERS (Other M/C)	\$9,061,000	\$4,530,500	\$8,171,000	\$4,085,500	\$9,338,000	\$4,669,000	\$277,000	\$138,500	\$1,167,000	\$583,500
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,442,000	\$721,000	\$1,065,000	\$532,500	\$989,000	\$494,500	-\$453,000	-\$226,500	-\$76,000	-\$38,000
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$15,383,199,000</b>	<b>\$7,541,786,450</b>	<b>\$16,328,303,000</b>	<b>\$7,897,633,250</b>	<b>\$17,178,793,000</b>	<b>\$8,331,152,550</b>	<b>\$1,795,594,000</b>	<b>\$789,366,100</b>	<b>\$850,490,000</b>	<b>\$433,519,300</b>
<b>OTHER</b>											
167	PERSONAL CARE SERVICES (Misc. Svcs.)	\$3,259,927,000	\$0	\$3,261,974,000	\$0	\$2,332,570,000	\$0	-\$927,357,000	\$0	-\$929,404,000	\$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	\$2,583,363,000	\$1,388,999,500	\$8,147,000	\$16,042,000	-\$15,521,000	-\$4,497,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2015 ESTIMATE COMPARED TO APPROPRIATION AND NOVEMBER 2014 ESTIMATE  
FISCAL YEAR 2014-15**

NO.	POLICY CHANGE TITLE	2014-15 APPROPRIATION		NOV. 2014 EST. FOR 2014-15		MAY 2015 EST. FOR 2014-15		DIFFERENCE MAY TO APPROPRIATION		DIFFERENCE MAY TO NOVEMBER	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER</b>											
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,462,530,000	\$1,462,530,000	\$1,537,016,000	\$1,537,016,000	\$1,516,618,000	\$1,516,618,000	\$54,088,000	\$54,088,000	-\$20,398,000	-\$20,398,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,406,132,000	\$0	\$1,359,930,000	\$0	\$1,362,595,000	\$0	-\$43,537,000	\$0	\$2,665,000	\$0
171	DENTAL SERVICES	\$578,288,000	\$267,310,900	\$795,450,000	\$377,632,250	\$1,050,674,000	\$406,538,200	\$472,386,000	\$139,227,300	\$255,224,000	\$28,905,950
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$265,000,000	\$0	\$265,000,000	\$0	\$245,500,000	\$0	-\$19,500,000	\$0	-\$19,500,000	\$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$158,421,000	\$0	\$191,787,000	\$0	\$195,908,000	\$0	\$37,487,000	\$0	\$4,121,000	\$0
177	MEDI-CAL TCM PROGRAM	\$44,554,000	\$0	\$41,394,000	\$0	\$41,535,000	\$0	-\$3,019,000	\$0	\$141,000	\$0
178	EPSDT SCREENS	\$38,799,000	\$18,478,650	\$39,065,000	\$19,070,350	\$37,638,000	\$18,365,700	-\$1,161,000	-\$112,950	-\$1,427,000	-\$704,650
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$32,158,000	\$16,079,000	\$38,831,000	\$19,415,500	\$39,350,000	\$19,675,000	\$7,192,000	\$3,596,000	\$519,000	\$259,500
183	LAWSUITS/CLAIMS	\$7,865,000	\$3,932,500	\$7,921,000	\$3,959,500	\$7,921,000	\$3,960,500	\$56,000	\$28,000	\$0	\$1,000
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,478,000	\$1,239,000	\$2,243,000	\$1,121,500	\$2,042,000	\$1,021,000	-\$436,000	-\$218,000	-\$201,000	-\$100,500
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$0	\$1,799,000	\$0	\$1,799,000	\$0	\$514,000	\$0	\$0	\$0
195	BASE RECOVERIES	-\$266,285,000	-\$134,032,000	-\$268,768,000	-\$135,282,000	-\$297,905,000	-\$149,948,000	-\$31,620,000	-\$15,916,000	-\$29,137,000	-\$14,666,000
	<b>OTHER SUBTOTAL</b>	<b>\$9,566,368,000</b>	<b>\$3,008,495,550</b>	<b>\$9,872,526,000</b>	<b>\$3,216,429,600</b>	<b>\$9,119,608,000</b>	<b>\$3,205,229,900</b>	<b>-\$446,760,000</b>	<b>\$196,734,350</b>	<b>-\$752,918,000</b>	<b>-\$11,199,700</b>
	<b>GRAND TOTAL</b>	<b>\$26,592,467,000</b>	<b>\$10,607,517,000</b>	<b>\$28,326,922,000</b>	<b>\$11,244,674,850</b>	<b>\$28,474,016,000</b>	<b>\$11,682,162,850</b>	<b>\$1,881,549,000</b>	<b>\$1,074,645,850</b>	<b>\$147,094,000</b>	<b>\$437,488,000</b>

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2015 ESTIMATE COMPARED TO NOVEMBER 2014 ESTIMATE  
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2015-16		MAY 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>							
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL			\$93,271,000	\$38,806,000	\$93,271,000	\$38,806,000
5	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL			\$16,482,000	\$5,768,700	\$16,482,000	\$5,768,700
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$109,753,000</b>	<b>\$44,574,700</b>	<b>\$109,753,000</b>	<b>\$44,574,700</b>
<b>DRUG MEDI-CAL</b>							
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$105,657,000	\$32,811,000	\$40,057,000	\$12,424,000	-\$65,600,000	-\$20,387,000
63	NARCOTIC TREATMENT PROGRAM	\$77,949,000	\$0	\$85,534,000	\$0	\$7,585,000	\$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$36,657,000	\$0	\$20,779,000	\$0	-\$15,878,000	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$63,887,000	\$19,610,000	\$47,904,000	\$14,832,000	-\$15,983,000	-\$4,778,000
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM	-\$27,850,000	\$0			\$27,850,000	\$0
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$256,300,000</b>	<b>\$52,421,000</b>	<b>\$194,274,000</b>	<b>\$27,256,000</b>	<b>-\$62,026,000</b>	<b>-\$25,165,000</b>
<b>MENTAL HEALTH</b>							
69	SMHS FOR ADULTS	\$1,145,028,000	\$71,820,000	\$1,149,581,000	\$68,885,000	\$4,553,000	-\$2,935,000
70	SMHS FOR CHILDREN	\$990,486,000	\$39,354,000	\$992,419,000	\$43,095,000	\$1,933,000	\$3,741,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$2,135,514,000</b>	<b>\$111,174,000</b>	<b>\$2,142,000,000</b>	<b>\$111,980,000</b>	<b>\$6,486,000</b>	<b>\$806,000</b>
<b>MANAGED CARE</b>							
109	TWO PLAN MODEL	\$9,425,937,000	\$4,547,770,800	\$10,518,318,000	\$5,119,314,000	\$1,092,381,000	\$571,543,200
111	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,652,444,000	\$2,260,055,300	\$4,589,386,000	\$2,221,705,300	-\$63,058,000	-\$38,350,000
112	GEOGRAPHIC MANAGED CARE	\$1,819,186,000	\$881,375,500	\$2,050,257,000	\$994,887,900	\$231,071,000	\$113,512,400
116	REGIONAL MODEL	\$388,228,000	\$184,337,950	\$750,730,000	\$365,171,550	\$362,502,000	\$180,833,600
119	PACE (Other M/C)	\$315,767,000	\$157,883,500	\$295,935,000	\$147,967,500	-\$19,832,000	-\$9,916,000
120	DENTAL MANAGED CARE (Other M/C)	\$103,902,000	\$51,951,000	\$146,820,000	\$60,779,700	\$42,918,000	\$8,828,700
121	SENIOR CARE ACTION NETWORK (Other M/C)	\$43,997,000	\$21,998,500	\$47,202,000	\$23,601,000	\$3,205,000	\$1,602,500
125	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,003,000	\$3,501,500	\$7,003,000	\$3,501,500	\$0	\$0
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$1,065,000	\$532,500	\$976,000	\$488,000	-\$89,000	-\$44,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$16,757,529,000</b>	<b>\$8,109,406,550</b>	<b>\$18,406,627,000</b>	<b>\$8,937,416,450</b>	<b>\$1,649,098,000</b>	<b>\$828,009,900</b>
<b>OTHER</b>							
167	PERSONAL CARE SERVICES (Misc. Svcs.)	\$3,417,045,000	\$0	\$845,295,000	\$0	-\$2,571,750,000	\$0
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,637,307,000	\$1,415,148,000	\$2,618,021,000	\$1,408,764,500	-\$19,286,000	-\$6,383,500
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,641,475,000	\$1,641,475,000	\$1,636,699,000	\$1,636,699,000	-\$4,776,000	-\$4,776,000

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES  
MAY 2015 ESTIMATE COMPARED TO NOVEMBER 2014 ESTIMATE  
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	NOV. 2014 EST. FOR 2015-16		MAY 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,514,429,000	\$0	\$1,541,478,000	\$0	\$27,049,000	\$0
171	DENTAL SERVICES	\$823,747,000	\$392,984,950	\$1,101,822,000	\$428,145,500	\$278,075,000	\$35,160,550
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$265,000,000	\$0	\$206,500,000	\$0	-\$58,500,000	\$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$153,558,000	\$0	\$162,286,000	\$0	\$8,728,000	\$0
177	MEDI-CAL TCM PROGRAM	\$44,292,000	\$0	\$47,090,000	\$0	\$2,798,000	\$0
178	EPSDT SCREENS	\$39,065,000	\$19,070,350	\$38,736,000	\$18,901,500	-\$329,000	-\$168,850
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,858,000	\$20,429,000	\$44,659,000	\$22,329,500	\$3,801,000	\$1,900,500
183	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$3,690,000	\$1,845,000	\$1,825,000	\$912,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,356,000	\$1,178,000	\$2,152,000	\$1,076,000	-\$204,000	-\$102,000
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$0	\$1,285,000	\$0	\$0	\$0
195	BASE RECOVERIES	-\$265,697,000	-\$133,736,000	-\$277,433,000	-\$139,644,000	-\$11,736,000	-\$5,908,000
	<b>OTHER SUBTOTAL</b>	<b>\$10,316,585,000</b>	<b>\$3,357,481,800</b>	<b>\$7,972,280,000</b>	<b>\$3,378,117,000</b>	<b>-\$2,344,305,000</b>	<b>\$20,635,200</b>
	<b>GRAND TOTAL</b>	<b>\$29,465,928,000</b>	<b>\$11,630,483,350</b>	<b>\$28,824,934,000</b>	<b>\$12,499,344,150</b>	<b>-\$640,994,000</b>	<b>\$868,860,800</b>

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

NO.	POLICY CHANGE TITLE	MAY 2015 EST. FOR 2014-15		MAY 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>ELIGIBILITY</b>							
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% F	\$59,181,000	\$24,603,000	\$93,271,000	\$38,806,000	\$34,090,000	\$14,203,000
5	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FP	\$15,844,000	\$5,545,400	\$16,482,000	\$5,768,700	\$638,000	\$223,300
	<b>ELIGIBILITY SUBTOTAL</b>	<b>\$75,025,000</b>	<b>\$30,148,400</b>	<b>\$109,753,000</b>	<b>\$44,574,700</b>	<b>\$34,728,000</b>	<b>\$14,426,300</b>
<b>DRUG MEDI-CAL</b>							
62	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$31,955,000	\$9,159,000	\$40,057,000	\$12,424,000	\$8,102,000	\$3,265,000
63	NARCOTIC TREATMENT PROGRAM	\$78,650,000	\$0	\$85,534,000	\$0	\$6,884,000	\$0
64	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$21,243,000	\$0	\$20,779,000	\$0	-\$464,000	\$0
65	RESIDENTIAL TREATMENT SERVICES	\$3,956,000	\$0	\$47,904,000	\$14,832,000	\$43,948,000	\$14,832,000
	<b>DRUG MEDI-CAL SUBTOTAL</b>	<b>\$135,804,000</b>	<b>\$9,159,000</b>	<b>\$194,274,000</b>	<b>\$27,256,000</b>	<b>\$58,470,000</b>	<b>\$18,097,000</b>
<b>MENTAL HEALTH</b>							
69	SMHS FOR ADULTS	\$1,025,597,000	\$67,264,000	\$1,149,581,000	\$68,885,000	\$123,984,000	\$1,621,000
70	SMHS FOR CHILDREN	\$939,189,000	\$39,209,000	\$992,419,000	\$43,095,000	\$53,230,000	\$3,886,000
	<b>MENTAL HEALTH SUBTOTAL</b>	<b>\$1,964,786,000</b>	<b>\$106,473,000</b>	<b>\$2,142,000,000</b>	<b>\$111,980,000</b>	<b>\$177,214,000</b>	<b>\$5,507,000</b>
<b>MANAGED CARE</b>							
109	TWO PLAN MODEL	\$9,744,574,000	\$4,738,584,350	\$10,518,318,000	\$5,119,314,000	\$773,744,000	\$380,729,650
111	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,567,587,000	\$2,210,206,450	\$4,589,386,000	\$2,221,705,300	\$21,799,000	\$11,498,850
112	GEOGRAPHIC MANAGED CARE	\$1,862,393,000	\$902,681,150	\$2,050,257,000	\$994,887,900	\$187,864,000	\$92,206,750
116	REGIONAL MODEL	\$579,530,000	\$279,653,050	\$750,730,000	\$365,171,550	\$171,200,000	\$85,518,500
119	PACE (Other M/C)	\$228,353,000	\$114,176,500	\$295,935,000	\$147,967,500	\$67,582,000	\$33,791,000
120	DENTAL MANAGED CARE (Other M/C)	\$140,401,000	\$57,873,550	\$146,820,000	\$60,779,700	\$6,419,000	\$2,906,150
121	SENIOR CARE ACTION NETWORK (Other M/C)	\$45,628,000	\$22,814,000	\$47,202,000	\$23,601,000	\$1,574,000	\$787,000
125	AIDS HEALTHCARE CENTERS (Other M/C)	\$9,338,000	\$4,669,000	\$7,003,000	\$3,501,500	-\$2,335,000	-\$1,167,500
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$989,000	\$494,500	\$976,000	\$488,000	-\$13,000	-\$6,500
	<b>MANAGED CARE SUBTOTAL</b>	<b>\$17,178,793,000</b>	<b>\$8,331,152,550</b>	<b>\$18,406,627,000</b>	<b>\$8,937,416,450</b>	<b>\$1,227,834,000</b>	<b>\$606,263,900</b>
<b>OTHER</b>							
167	PERSONAL CARE SERVICES (Misc. Svcs.)	\$2,332,570,000	\$0	\$845,295,000	\$0	-\$1,487,275,000	\$0

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

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

NO.	POLICY CHANGE TITLE	MAY 2015 EST. FOR 2014-15		MAY 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
<b>OTHER</b>							
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,583,363,000	\$1,388,999,500	\$2,618,021,000	\$1,408,764,500	\$34,658,000	\$19,765,000
169	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,516,618,000	\$1,516,618,000	\$1,636,699,000	\$1,636,699,000	\$120,081,000	\$120,081,000
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,362,595,000	\$0	\$1,541,478,000	\$0	\$178,883,000	\$0
171	DENTAL SERVICES	\$1,050,674,000	\$406,538,200	\$1,101,822,000	\$428,145,500	\$51,148,000	\$21,607,300
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$245,500,000	\$0	\$206,500,000	\$0	-\$39,000,000	\$0
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$195,908,000	\$0	\$162,286,000	\$0	-\$33,622,000	\$0
177	MEDI-CAL TCM PROGRAM	\$41,535,000	\$0	\$47,090,000	\$0	\$5,555,000	\$0
178	EPSDT SCREENS	\$37,638,000	\$18,365,700	\$38,736,000	\$18,901,500	\$1,098,000	\$535,800
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$39,350,000	\$19,675,000	\$44,659,000	\$22,329,500	\$5,309,000	\$2,654,500
183	LAWSUITS/CLAIMS	\$7,921,000	\$3,960,500	\$3,690,000	\$1,845,000	-\$4,231,000	-\$2,115,500
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,042,000	\$1,021,000	\$2,152,000	\$1,076,000	\$110,000	\$55,000
187	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,799,000	\$0	\$1,285,000	\$0	-\$514,000	\$0
195	BASE RECOVERIES	-\$297,905,000	-\$149,948,000	-\$277,433,000	-\$139,644,000	\$20,472,000	\$10,304,000
	<b>OTHER SUBTOTAL</b>	<b>\$9,119,608,000</b>	<b>\$3,205,229,900</b>	<b>\$7,972,280,000</b>	<b>\$3,378,117,000</b>	<b>-\$1,147,328,000</b>	<b>\$172,887,100</b>
	<b>GRAND TOTAL</b>	<b>\$28,474,016,000</b>	<b>\$11,682,162,850</b>	<b>\$28,824,934,000</b>	<b>\$12,499,344,150</b>	<b>\$350,918,000</b>	<b>\$817,181,300</b>

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

## MEDI-CAL PROGRAM BASE POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
<b><u>ELIGIBILITY</u></b>	
3	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL
5	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL
<b><u>DRUG MEDI-CAL</u></b>	
62	INTENSIVE OUTPATIENT TREATMENT SERVICES
63	NARCOTIC TREATMENT PROGRAM
64	OUTPATIENT DRUG FREE TREATMENT SERVICES
65	RESIDENTIAL TREATMENT SERVICES
<b><u>MENTAL HEALTH</u></b>	
69	SMHS FOR ADULTS
70	SMHS FOR CHILDREN
<b><u>MANAGED CARE</u></b>	
109	TWO PLAN MODEL
111	<a href="#">COUNTY ORGANIZED HEALTH SYSTEMS</a>
112	GEOGRAPHIC MANAGED CARE
116	REGIONAL MODEL
119	PACE (Other M/C)
120	DENTAL MANAGED CARE (Other M/C)
121	SENIOR CARE ACTION NETWORK (Other M/C)
125	AIDS HEALTHCARE CENTERS (Other M/C)
127	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)
<b><u>OTHER</u></b>	
167	PERSONAL CARE SERVICES (Misc. Svcs.)
168	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS
169	<a href="#">MEDICARE PAYMENTS - PART D PHASED-DOWN</a>
170	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)
171	DENTAL SERVICES
172	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC
174	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)
177	MEDI-CAL TCM PROGRAM

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

<b>POLICY CHANGE NUMBER</b>	<b>POLICY CHANGE TITLE</b>
	<b>OTHER</b>
178	EPSDT SCREENS
179	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
183	LAWSUITS/CLAIMS
185	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
187	<a href="#">CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)</a>
195	BASE RECOVERIES

## MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$59,181,000	\$93,271,000
- STATE FUNDS	\$24,603,000	\$38,806,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$59,181,000	\$93,271,000
STATE FUNDS	\$24,603,000	\$38,806,000
FEDERAL FUNDS	\$34,578,000	\$54,465,000

### DESCRIPTION

**Purpose:**

This policy change estimates the benefits cost for the Medi-Cal Access Program mothers with incomes between 213-322% 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 267-322% 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 213-322% 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 November 2014 estimate assumed a monthly average of 4,708 pregnant women for FY 2014-15. Based on actual enrollment data through January 2015, the May 2015 estimate assumes a monthly average of 3,774 pregnant women for FY 2014-15.
- Updated per-member-per month (PMPM) and per-member-per-delivery (PMPD) based on negotiated rates effective 10/1/14.
- May and June 2015 estimated capitation payments moved to FY 2015-16.
- Due to the timing of when June 2016 estimated capitation payments are received, they are assumed to be paid in FY 2016-17.

**MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL**

BASE POLICY CHANGE NUMBER: 3

**Methodology:**

- 1) Based on actual enrollment data from September 2012 through January 2015, the Department estimates the following:

	<b>FY 2014-15</b>	<b>FY 2015-16</b>
Average monthly caseload	3,774	4,502
Deliveries	443	531

- 2) The Department estimates the following PMPM and PMPD costs:

	<b>FY 2014-15</b>	<b>FY 2015-16</b>
PMPM: July-Sept 2014	\$493.37	
PMPM: Oct-Sept 2015	\$495.83	\$495.83
PMPD: July-Sept 2014	\$10,204.10	
PMPD: Oct-Sept 2015	\$11,582.93	\$11,582.93

- 3) Medi-Cal Access Program subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total \$3,918,000 in FY 2014-15 and \$4,701,000 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)

<b>FY 2014-15</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>
65% Title XXI FFP/35% Perinatal Insurance Fund	\$56,723	\$19,853	\$36,870
100% Perinatal Insurance Fund	\$6,376	\$6,376	\$0
Premiums	(\$3,918)	(\$1,626)	(\$2,292)
<b>Total</b>	<b>\$59,181</b>	<b>\$24,603</b>	<b>\$34,578</b>

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>TF</b>	<b>SF</b>	<b>FF</b>
65% Title XXI FFP/35% Perinatal Insurance Fund	\$88,023	\$30,808	\$57,215
100% Perinatal Insurance Fund	\$9,949	\$9,949	
Premiums	(\$4,701)	(\$1,951)	(\$2,750)
<b>Total</b>	<b>\$93,271</b>	<b>\$38,806</b>	<b>\$54,465</b>

**Funding:**

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

## MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$15,844,000	\$16,482,000
- STATE FUNDS	\$5,545,400	\$5,768,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,844,000	\$16,482,000
STATE FUNDS	\$5,545,400	\$5,768,700
FEDERAL FUNDS	\$10,298,600	\$10,713,300

### DESCRIPTION

**Purpose:**

This policy change estimates the benefits cost for the Medi-Cal Access Program linked infants with incomes between 266-322% 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 Access 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 Optional Targeted Low Income Children's Program (OTLICP) 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 a 42% decrease of 1<sup>st</sup> and 2<sup>nd</sup> year infants in FY 2014-15. This is based upon updated enrollment projections from PC 3 Medi-Cal Access Program Mothers 213-322% FPL.
- The percent of infants with incomes between 266% and 322% FPL decreased from 59.5% to 46.4% when compared to November. Infants with incomes between 212% and 266% are budgeted in the managed care policy changes as part of the OTLICP.

**Methodology:**

1. The Department estimates 4,267 average monthly infants with family income between 266% and 322% FPL will enroll in FY 2014-15 and 3,553 in FY 2015-16.

**MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL****BASE POLICY CHANGE NUMBER: 5**

2. The Department estimates the weighted average monthly per-member-per-month (PMPM) cost in FY 2014-15 is \$322.45 and \$399.60 in FY 2015-16. The increase from FY 2014-15 to FY 2015-16 is due to an increase in the number of infants calculated at the first two-month infant rate.
3. Medi-Cal Access Program subscribers are subject to monthly premiums. Premiums are estimated to total \$666,000 in FY 2014-15 and \$554,000 in FY 2015-16.
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)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Benefits	\$16,510	\$5,779	\$10,732
Premiums	(\$666)	(\$233)	(\$433)
<b>Net</b>	<b>\$15,844</b>	<b>\$5,545</b>	<b>\$10,299</b>

<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Benefits	\$17,037	\$5,963	\$11,074
Premiums	(\$554)	(\$194)	(\$360)
<b>Net</b>	<b>\$16,482</b>	<b>\$5,769</b>	<b>\$10,714</b>

**Funding:**

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

## INTENSIVE OUTPATIENT TREATMENT SERVICES

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$31,955,000</b>	<b>\$40,057,000</b>
<b>- STATE FUNDS</b>	<b>\$9,159,000</b>	<b>\$12,424,000</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$31,955,000</b>	<b>\$40,057,000</b>
<b>STATE FUNDS</b>	<b>\$9,159,000</b>	<b>\$12,424,000</b>
<b>FEDERAL FUNDS</b>	<b>\$22,796,000</b>	<b>\$27,633,000</b>

### DESCRIPTION

**Purpose:**

This policy change estimates the reimbursement funds for the Drug Medi-Cal (DMC), Intensive Outpatient Treatment (IOT) 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.

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%. This service was limited to Early and Periodic Screening Diagnosis and Treatment (EPSDT), pregnant and postpartum women.

## INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 62

With the provisions of the Affordable Care Act (ACA) starting January 1, 2014, 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 and are considered part of the ACA mandatory expansion. The populations are described below:

ACA Population	Description	Funding
Expanded	Medi-Cal eligible and enrolled, but not receiving services: Non-EPSDT, non-pregnant/postpartum	50% GF/50% FF Title XIX; Certain aid codes 65% FF Title XXI
Mandatory	Medi-Cal eligible, but not enrolled in Medi-Cal	50% GF/50% FFP Title XIX Certain aid codes 65% FF Title XXI
Optional	Previously ineligible for Medi-Cal before ACA	100% FFP Title XIX

Starting FY 2014-15, the DMC reimbursement rate was adjusted to eliminate the county administration cost component. The adjusted reimbursement rate funds the direct service costs. 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 updated for September 2014 through January 2015.
- 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. The caseload projections are based on the 57 months of the most recent complete caseload data, January 2010 through September 2014.
3. The UOS is based on the most recent complete data, July 2013-June 2014 to calculate an average UOS.
4. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
5. 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.
6. The cost estimate is developed by the following: UOS x Rate x Caseload.

**INTENSIVE OUTPATIENT TREATMENT SERVICES****BASE POLICY CHANGE NUMBER: 62**

7. Amounts may differ due to rounding.

			FY 2014-15		FY 2015-16	
FY 2014-15	UOS	Rates	Caseload	Total	Caseload	Total
<b>Current</b>						
Regular	16.6	\$56.44	943	\$884,000	747	\$700,000
EPSDT	38.5	\$56.44	3,196	\$6,945,000	3,090	\$6,714,000
Perinatal	31.2	\$80.78	394	\$993,000	396	\$998,000
Subtotal			4,533	\$8,822,000	4,233	\$8,412,000
<b>Expanded</b>						
Regular	16.6	\$56.44	18,433	\$17,270,000	18,433	\$17,270,000
EPSDT	38.5	\$56.44	-	\$0	-	\$0
Perinatal	31.2	\$80.78	2,162	\$5,449,000	2,162	\$5,450,000
Subtotal			20,595	\$22,719,000	20,595	\$22,720,000
<b>Mandatory</b>						
Regular	16.6	\$56.44	102	\$95,000	119	\$111,000
EPSDT	38.5	\$56.44	1,390	\$3,020,000	1,622	\$3,524,000
Perinatal	31.2	\$80.78	157	\$395,000	183	\$461,000
Subtotal			1,667	\$3,510,000	1,945	\$4,096,000
<b>Optional</b>						
Regular	16.6	\$56.44	7,052	\$6,607,000	7,363	\$6,898,000
EPSDT	38.5	\$56.44	-	\$0	-	\$0
Perinatal	31.2	\$80.78	827	\$2,085,000	864	\$2,177,000
Subtotal			7,879	\$8,692,000	8,227	\$9,075,000
<b>Total</b>				\$43,743,000		\$44,303,000

**INTENSIVE OUTPATIENT TREATMENT SERVICES****BASE POLICY CHANGE NUMBER: 62**

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

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2014-15</b>	<b>FY 2015-16</b>
Regular	\$17,868,000	\$4,467,000	\$0
Perinatal	\$641,000	\$160,250	\$0
<b>FY 2013-14</b>	<b>\$18,509,000</b>	<b>\$4,627,250</b>	<b>\$0</b>
<b>Current</b>			
Regular	\$884,000	\$663,000	\$221,000
EPSDT	\$6,945,000	\$5,208,750	\$1,736,250
Perinatal	\$993,000	\$744,750	\$248,250
<b>Expanded</b>			
Regular	\$17,270,000	\$12,952,500	\$4,317,500
Perinatal	\$5,449,000	\$4,086,750	\$1,362,250
<b>Mandatory</b>			
Regular	\$95,000	\$71,250	\$23,750
EPSDT	\$3,020,000	\$2,265,000	\$755,000
Perinatal	\$395,000	\$296,250	\$98,750
<b>Optional</b>			
Regular	\$6,607,000	\$4,955,250	\$1,651,750
Perinatal	\$2,085,000	\$1,563,750	\$521,250
<b>FY 2014-15</b>	<b>\$43,743,000</b>	<b>\$32,807,250</b>	<b>\$10,935,750</b>
<b>Current</b>			
Regular	\$700,000	\$0	\$525,000
EPSDT	\$6,714,000	\$0	\$5,035,500
Perinatal	\$998,000	\$0	\$748,500
<b>Expanded</b>			
Regular	\$17,270,000	\$0	\$12,952,500
Perinatal	\$5,450,000	\$0	\$4,087,500
<b>Mandatory</b>			
Regular	\$111,000	\$0	\$83,250
EPSDT	\$3,524,000	\$0	\$2,643,000
Perinatal	\$461,000	\$0	\$345,750
<b>Optional</b>			
Regular	\$6,898,000	\$0	\$5,173,500
Perinatal	\$2,177,000	\$0	\$1,632,750
<b>FY 2015-16</b>	<b>\$44,303,000</b>	<b>\$0</b>	<b>\$33,227,250</b>
<b>Total</b>		<b>\$37,434,500</b>	<b>\$44,163,000</b>

**INTENSIVE OUTPATIENT TREATMENT SERVICES****BASE POLICY CHANGE NUMBER: 62**

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

<b>FY 2014-15</b>	<b>TF</b>	<b>FF Title XIX</b>	<b>FF Title XXI</b>	<b>CF</b>	<b>GF</b>
<b>Current</b>					
Regular & EPSDT	\$10,339,000	\$5,144,000	\$33,000	\$5,162,000	\$0
Perinatal	\$905,000	\$9,000	\$579,000	\$317,000	\$0
<b>Expanded</b>					
Regular & EPSDT	\$12,952,000	\$6,411,000	\$84,000	\$0	\$6,457,000
Perinatal	\$4,087,000	\$43,000	\$2,614,000	\$0	\$1,430,000
<b>Mandatory</b>					
Regular & EPSDT	\$2,336,000	\$1,168,000	\$0	\$0	\$1,168,000
Perinatal	\$296,000	\$3,000	\$189,000	\$0	\$104,000
<b>Optional</b>					
Regular & EPSDT	\$4,955,000	\$4,955,000	\$0	\$0	\$0
Perinatal	\$1,564,000	\$1,564,000	\$0	\$0	\$0
<b>Total</b>	<b>\$37,434,000</b>	<b>\$19,297,000</b>	<b>\$3,499,000</b>	<b>\$5,479,000</b>	<b>\$9,159,000</b>

<b>FY 2015-16</b>	<b>TF</b>	<b>FF Title XIX</b>	<b>FF Title XXI</b>	<b>CF</b>	<b>GF</b>
<b>Current</b>					
Regular & EPSDT	\$7,518,000	\$3,755,000	\$5,000	\$3,758,000	\$0
Perinatal	\$997,000	\$10,000	\$638,000	\$349,000	\$0
<b>Expanded</b>					
Regular & EPSDT	\$17,270,000	\$8,549,000	\$112,000	\$0	\$8,609,000
Perinatal	\$5,450,000	\$57,000	\$3,486,000	\$0	\$1,907,000
<b>Mandatory</b>					
Regular & EPSDT	\$3,505,000	\$1,752,000	\$1,000	\$0	\$1,752,000
Perinatal	\$445,000	\$5,000	\$284,000	\$0	\$156,000
<b>Optional</b>					
Regular & EPSDT	\$6,825,000	\$6,825,000	\$0	\$0	\$0
Perinatal	\$2,154,000	\$2,154,000	\$0	\$0	\$0
<b>Total</b>	<b>\$44,164,000</b>	<b>\$23,107,000</b>	<b>\$4,526,000</b>	<b>\$4,107,000</b>	<b>\$12,424,000</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$78,650,000	\$85,534,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$78,650,000	\$85,534,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$78,650,000	\$85,534,000

### 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.

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) starting January 1, 2014, 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 and are considered part of the ACA mandatory expansion. The populations are described below:

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 63**

ACA Population	Description	Funding
Mandatory	Medi-Cal eligible, but not enrolled in Medi-Cal	50% GF/50% FFP Title XIX Certain aid codes 65% FF Title XXI
Optional	Previously ineligible for Medi-Cal before ACA	100% FFP Title XIX

Starting FY 2014-15, the DMC reimbursement rate was adjusted to eliminate the county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. 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 updated enrollment data.
- The percentage of ACA adults were adjusted to align with projections for ACA mandatory caseload.
- The Units of Service (UOS) were adjusted using the most current annual FY 2013-14 client caseload.

**Methodology:**

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent, and Perinatal.
2. The caseload projections are based on 57 months of the most recent complete caseload data, January 2010 through September 2014.
3. The UOS is based on the most recent complete data, July 2012-June 2013 to calculate an average UOS.
4. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
5. 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.
6. The cost estimate is developed by the following: UOS x Rates x Caseload.
7. Amounts may differ due to rounding.

			FY 2014-15		FY 2015-16	
	UOS	Rates	Caseload	Total	Caseload	Total
<b>Current Population</b>						
<b>Regular</b>						
Dosing	213.3	\$10.80	37,515	\$86,421,000	38,170	\$87,930,000
Individual	94.4	\$13.48	37,515	\$47,738,000	38,170	\$48,572,000
Group	0.3	\$2.91	37,515	\$33,000	38,170	\$33,000
Total				\$134,192,000		\$136,535,000

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 63**

			FY 2014-15		FY 2015-16	
Current Population	UOS	Rates	Caseload	Total	Caseload	Total
<b>EPSDT</b>						
Dosing	116.8	\$10.80	383	\$483,000	383	\$483,000
Individual	58.7	\$13.48	383	\$303,000	383	\$303,000
Group	0.1	\$2.91	383	\$0	383	\$0
Total				\$786,000		\$786,000
<b>Perinatal</b>						
Dosing	103.2	\$11.79	209	\$254,000	226	\$275,000
Individual	37.4	\$21.06	209	\$165,000	226	\$178,000
Group	0.9	\$7.03	209	\$1,000	226	\$1,000
Total				\$420,000		\$454,000
<b>Mandatory</b>						
<b>Regular</b>						
Dosing	213.3	\$10.80	855	\$1,969,000	994	\$2,290,000
Individual	94.4	\$13.48	855	\$1,087,000	994	\$1,265,000
Group	0.3	\$2.91	855	\$1,000	994	\$1,000
Total				\$3,057,000		\$3,556,000
<b>EPSDT</b>						
Dosing	116.8	\$10.80	5	\$6,000	9	\$11,000
Individual	58.7	\$13.48	5	\$4,000	9	\$7,000
Group	0.1	\$2.91	5	\$0	9	\$0
Total				\$10,000		\$18,000
<b>Perinatal</b>						
Dosing	103.2	\$11.79	4	\$5,000	5	\$7,000
Individual	37.4	\$21.06	4	\$3,000	5	\$4,000
Group	0.9	\$7.03	4	\$0	5	\$0
Total				\$8,000		\$11,000
<b>Optional</b>						
<b>Regular</b>						
Dosing	213.3	\$10.80	4,029	\$9,281,000	4,206	\$9,689,000
Individual	94.4	\$13.48	4,029	\$5,127,000	4,206	\$5,352,000
Group	0.3	\$2.91	4,029	\$4,000	4,206	\$4,000
Total				\$14,412,000		\$15,045,000
<b>Perinatal</b>						
Dosing	103.2	\$11.79	22	\$27,000	26	\$31,000
Individual	37.4	\$21.06	22	\$17,000	26	\$20,000
Group	0.9	\$7.03	22	\$0	26	\$0
Total				\$44,000		\$51,000
			TOTAL	\$152,929,000		\$156,456,000

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 63**

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

<b>Fiscal Year</b>	<b>Accrual</b>	<b>FY 2014-15</b>	<b>FY 2015-16</b>
Regular	\$124,494,000	\$31,124,000	\$0
Minor Consent	\$93,000	\$23,000	\$0
Perinatal	\$425,000	\$106,000	\$0
<b>FY 2013-14</b>	<b>\$125,012,000</b>	<b>\$31,253,000</b>	<b>\$0</b>
<b>Current</b>			
Regular	\$134,978,000	\$101,233,500	\$33,744,500
Perinatal	\$420,000	\$315,000	\$105,000
<b>Mandatory</b>			
Regular	\$3,067,000	\$2,300,250	\$766,750
Perinatal	\$8,000	\$6,000	\$2,000
<b>Optional</b>			
Regular	\$14,412,000	\$10,809,000	\$3,603,000
Perinatal	\$44,000	\$33,000	\$11,000
<b>FY 2014-15</b>	<b>\$152,929,000</b>	<b>\$114,696,750</b>	<b>\$38,232,250</b>
<b>Current</b>			
Regular	\$137,321,000	\$0	\$102,990,750
Perinatal	\$454,000	\$0	\$340,500
<b>Mandatory</b>			
Regular	\$3,574,000	\$0	\$2,680,500
Perinatal	\$11,000	\$0	\$8,250
<b>Optional</b>			
Regular	\$15,045,000	\$0	\$11,283,750
Perinatal	\$51,000	\$0	\$38,250
<b>FY 2015-16</b>	<b>\$156,456,000</b>	<b>\$0</b>	<b>\$117,342,000</b>
<b>TOTAL</b>		<b>\$145,949,750</b>	<b>\$155,574,250</b>

**NARCOTIC TREATMENT PROGRAM****BASE POLICY CHANGE NUMBER: 63**

9. 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.

<b>FY 2014-15</b>	<b>TF</b>	<b>FF (Title XIX)</b>	<b>FF (Title XXI)</b>	<b>County</b>
<b>Current</b>				
Regular	\$132,357,000	\$65,517,000	\$860,000	\$65,980,000
Minor Consent	\$23,000	\$0	\$0	\$23,000
Perinatal	\$420,000	\$4,000	\$269,000	\$147,000
<b>Mandatory</b>				
Regular	\$2,301,000	\$1,139,000	\$15,000	\$1,147,000
Perinatal	\$6,000	\$0	\$4,000	\$2,000
<b>Optional</b>				
Regular	\$10,809,000	\$10,809,000	\$0	\$0
Perinatal	\$33,000	\$33,000	\$0	\$0
<b>Total</b>	<b>\$145,949,000</b>	<b>\$77,502,000</b>	<b>\$1,148,000</b>	<b>\$67,299,000</b>

<b>FY 2015-16</b>	<b>TF</b>	<b>FF (Title XIX)</b>	<b>FF (Title XXI)</b>	<b>County</b>
<b>Current</b>				
Regular	\$136,736,000	\$67,684,000	\$889,000	\$68,163,000
Perinatal	\$446,000	\$5,000	\$285,000	\$156,000
<b>Mandatory</b>				
Regular	\$3,446,000	\$1,706,000	\$22,000	\$1,718,000
Perinatal	\$11,000	\$0	\$7,000	\$4,000
<b>Optional</b>				
Regular	\$14,887,000	\$14,887,000	\$0	\$0
Perinatal	\$49,000	\$49,000	\$0	\$0
<b>Total</b>	<b>\$155,575,000</b>	<b>\$84,331,000</b>	<b>\$1,203,000</b>	<b>\$70,041,000</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$21,243,000	\$20,779,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$21,243,000	\$20,779,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$21,243,000	\$20,779,000

### 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.

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) starting January 1, 2014, 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 and are considered part of the ACA mandatory expansion. The populations are described below:

ACA Population	Description	Funding
Mandatory	Medi-Cal eligible, but not enrolled in Medi-Cal	50% GF/50% FFP Title XIX Certain aid codes 65% FF Title XXI
Optional	Previously ineligible for Medi-Cal before ACA	100% FFP Title XIX

Starting FY 2014-15, the DMC reimbursement rate was adjusted to eliminate the county administration cost component. The adjusted reimbursement rate funds the direct service costs only. The county administration costs can be found in the policy change titled DMC County Admin.

### Reason for Change from Prior Estimate:

- Updated ACA caseload based on additional actual enrollment data from September 2014 through January 2015.
- The percentage of ACA adults were adjusted to align with projections for ACA mandatory caseload.
- Updated the Units of Services (UOS) 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. The caseload projections are based on 57 months of the most recent complete caseload data, January 2010 through September 2014.
3. The Units of Service (UOS) data is based on the most recent complete data, July 2013-June 2014, to calculate an average UOS.
4. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
5. 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 the Department of Finance (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.
6. The cost estimate is developed by the following: UOS x Rate x Caseload.
7. 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
<b>Current Population</b>						
<b>Regular</b>						
Individual	2.8	\$67.38	21,403	\$4,038,000	20,575	\$3,882,000
Group	22.6	\$26.23	21,403	\$12,688,000	20,575	\$12,197,000
Subtotal				\$16,726,000		\$16,079,000
<b>EPSDT</b>						
Individual	4.8	\$67.38	6,552	\$2,119,000	7,161	\$2,316,000
Group	24	\$26.23	6,552	\$4,125,000	7,161	\$4,508,000
Subtotal				\$6,244,000		\$6,824,000
<b>Minor Consent</b>						
Individual	4.8	\$67.38	2,382	\$770,000	1,056	\$342,000
Group	21	\$26.23	2,382	\$1,312,000	1,056	\$582,000
Subtotal				\$2,082,000		\$924,000
<b>Perinatal</b>						
Individual	2.5	\$105.32	450	\$118,000	513	\$135,000
Group	14.6	\$63.33	450	\$416,000	513	\$474,000
Subtotal				\$534,000		\$609,000
<b>Mandatory</b>						
<b>Regular</b>						
Individual	2.8	\$67.38	1,332	\$251,000	1,553	\$293,000
Group	22.6	\$26.23	1,332	\$789,000	1,553	\$921,000
Subtotal				\$1,040,000		\$1,214,000
<b>EPSDT</b>						
Individual	4.8	\$67.38	498	\$161,000	581	\$188,000
Group	24	\$26.23	498	\$313,000	581	\$366,000
Subtotal				\$474,000		\$554,000
<b>Minor Consent</b>						
Individual	4.8	\$67.38	228	\$74,000	267	\$86,000
Group	21	\$26.23	228	\$125,000	267	\$147,000
Subtotal				\$199,000		\$233,000
<b>Perinatal</b>						
Individual	2.5	\$105.32	29	\$8,000	33	\$9,000
Group	14.6	\$63.33	29	\$27,000	33	\$31,000
Subtotal				\$35,000		\$40,000
<b>Optional</b>						
<b>Regular</b>						
Individual	2.8	\$67.38	9,724	\$1,835,000	10,154	\$1,916,000
Group	22.6	\$26.23	9,724	\$5,764,000	10,154	\$6,019,000
Subtotal				\$7,599,000		\$7,935,000
<b>EPSDT</b>						
Individual	4.8	\$67.38	-	\$0	-	\$0
Group	24	\$26.23	-	\$0	-	\$0
Subtotal				\$0		\$0

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

	UOS	Rates	FY 2014-15		FY 2015-16	
			Caseload	Total	Caseload	Total
<b>Optional</b>						
Perinatal						
Individual	2.5	\$105.32	138	\$36,000	145	\$38,000
Group	14.6	\$63.33	138	\$128,000	145	\$134,000
Subtotal				\$164,000		\$172,000
<b>Total</b>				\$35,097,000		\$ 34,584,000

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
Regular	\$46,804,000	\$11,701,000	\$0
Minor Consent	\$18,540,000	\$4,635,000	\$0
Perinatal	\$411,000	\$102,750	\$0
<b>FY 2013-14</b>	<b>\$65,755,000</b>	<b>\$16,438,750</b>	<b>\$0</b>
<b>Current</b>			
Regular	\$22,970,000	\$17,227,500	\$5,742,500
Minor Consent	\$2,082,000	\$1,561,500	\$520,500
Perinatal	\$534,000	\$400,500	\$133,500
<b>Mandatory</b>			
Regular	\$1,514,000	\$1,135,500	\$373,500
Minor Consent	\$199,000	\$149,250	\$125,000
Perinatal	\$35,000	\$26,250	\$5,500
<b>Optional</b>			
Regular	\$7,599,000	\$5,699,250	\$1,822,250
Perinatal	\$164,000	\$123,000	\$24,000
<b>FY 2014-15</b>	<b>\$35,097,000</b>	<b>\$26,322,750</b>	<b>\$8,746,750</b>
<b>Current</b>			
Regular	\$22,903,000	\$0	\$17,177,250
Minor Consent	\$924,000	\$0	\$693,000
Perinatal	\$609,000	\$0	\$456,750
<b>Mandatory</b>			
Regular	\$1,768,000	\$0	\$1,206,000
Minor Consent	\$233,000	\$0	\$402,750
Perinatal	\$40,000	\$0	\$18,000
<b>Optional</b>			
Regular	\$7,935,000	\$0	\$5,555,250
Perinatal	\$172,000	\$0	\$65,250
<b>FY 2015-16</b>	<b>\$34,584,000</b>	<b>\$0</b>	<b>\$25,574,250</b>
<b>Total</b>		<b>\$42,761,500</b>	<b>\$34,321,000</b>

## OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

9. 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
<b>Current</b>				
Regular	\$28,929,000	\$14,320,000	\$188,000	\$14,421,000
Minor Consent	\$6,197,000	\$0	\$0	\$6,197,000
Perinatal	\$503,000	\$5,000	\$322,000	\$176,000
<b>Mandatory</b>				
Regular	\$1,135,000	\$562,000	\$7,000	\$566,000
Minor Consent	\$149,000	\$0	\$0	\$149,000
Perinatal	\$26,000	\$0	\$17,000	\$9,000
<b>Optional</b>				
Regular	\$5,699,000	\$5,699,000	\$0	\$0
Perinatal	\$123,000	\$123,000	\$0	\$0
<b>Total</b>	<b>\$42,761,000</b>	<b>\$20,709,000</b>	<b>\$534,000</b>	<b>\$21,518,000</b>

FY 2015-16	TF	FF (Title XIX)	FF (Title XXI)	County
<b>Current</b>				
Regular	\$22,919,000	\$11,345,000	\$149,000	\$11,425,000
Minor Consent	\$1,214,000	\$0	\$0	\$1,214,000
Perinatal	\$591,000	\$6,000	\$378,000	\$207,000
<b>Mandatory</b>				
Regular	\$1,705,000	\$844,000	\$11,000	\$850,000
Minor Consent	\$225,000	\$0	\$0	\$225,000
Perinatal	\$39,000	\$0	\$25,000	\$14,000
<b>Optional</b>				
Regular	\$7,851,000	\$7,851,000	\$0	\$0
Perinatal	\$170,000	\$170,000	\$0	\$0
<b>Total</b>	<b>\$ 34,714,000</b>	<b>\$ 20,216,000</b>	<b>\$ 563,000</b>	<b>\$ 13,935,000</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$3,956,000	\$47,904,000
- STATE FUNDS	\$0	\$14,832,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,956,000	\$47,904,000
STATE FUNDS	\$0	\$14,832,000
FEDERAL FUNDS	\$3,956,000	\$33,072,000

### DESCRIPTION

**Purpose:**

This policy change estimates the reimbursement for the Drug Medi-Cal (DMC) Residential Treatment 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 (RTS) provides rehabilitation services to beneficiaries with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

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

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

The 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. Perinatal 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.

## RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 65

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) starting January 1, 2014, 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 and are considered part of the ACA mandatory expansion. The populations are described below:

ACA Population	Description	Funding
Expanded	Medi-Cal eligible and enrolled, but not receiving services: non-perinatal beginning July 1, 2015.	50% GF/50% FF Title XIX; Certain aid codes 65% FF Title XXI
Mandatory	Medi-Cal eligible, but not enrolled	50% GF/50% FFP Title XIX; Certain aid codes 65% FF Title XXI
Optional	Previously ineligible for Medi-Cal before ACA	100% FFP Title XIX

A waiver has been requested to permit provision of Residential Treatment Services to non-perinatal beneficiaries in facilities with no bed capacity limit. The waiver 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.

Starting FY 2014-15, the DMC reimbursement rate was adjusted to eliminate the county administration cost component. The adjusted reimbursement rate will fund the direct service costs only. 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 updated for September 2014 through January 2015. Also, fourteen additional counties are expected to participate in the waiver.

### 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 57 months of the most recent complete caseload data, January 2010 through September 2014.
3. The Units of Service (UOS) is based on the most recent complete data, July 2013-June 2014 to calculate an average UOS for existing caseload.
4. 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 2015-16 rates, see the Annual Rate Adjustment policy change.
5. The cost estimate is developed by the following, Caseload x UOS x Rates.

**RESIDENTIAL TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 65

6. Amounts may differ due to rounding.

FY 2014-15	Caseload	UOS	Rates	Total
<b>Current</b>				
Perinatal	301	60.0	\$99.43	\$1,796,000
<b>Mandatory</b>				
Perinatal	1,382	60.0	\$99.43	\$8,242,000
<b>Total</b>	1,683			\$10,038,000

FY 2015-16	Caseload	UOS	Rates	Total
<b>Current</b>				
Perinatal	286	60.0	\$99.43	\$1,706,000
<b>Mandatory</b>				
Perinatal	1,612	60.0	\$99.43	\$9,618,000
<b>Total</b>	1,898			\$11,324,000

7. 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	
<b>FY 2013-14</b>	\$1,388,000	\$347,000	\$0
<b>Current</b>			
Perinatal	\$1,796,000	\$1,347,000	\$449,000
<b>Mandatory</b>			
Perinatal	\$8,242,000	\$6,181,500	\$2,060,500
<b>FY 2014-15</b>	\$10,038,000	\$7,528,500	\$2,509,500
<b>Current</b>			
Perinatal	\$1,706,000	\$0	\$1,279,500
<b>Mandatory</b>			
Perinatal	\$9,618,000	\$0	\$7,213,500
<b>FY 2015-16</b>	\$11,324,000	\$0	\$8,493,000
<b>Total</b>		\$7,875,500	\$11,002,500

8. Assume the non-perinatal population will be able to access RTS effective July 1, 2015.

9. Assume the total number of beds available to the non-perinatal DMC beneficiaries seeking the RTS is 3,306.

10. 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.

$3,306 \times 260 \times \$99.43 = \$85,477,000$  Annual expenditures for the non-perinatal population seeking RTS

**RESIDENTIAL TREATMENT SERVICES****BASE POLICY CHANGE NUMBER: 65**

11. In FY 2015-16, twenty-two counties are expected to participate in providing the RTS to the non-perinatal population. Assume the 22 opt-in counties will begin to provide services effective July 1, 2015 and there will be a three month lag of costs from the start date for each county. The counties will need time to build up a network and inform beneficiaries of the new service. The estimated lagged cost for FY 2015-16 is \$42,376,000 on a cash basis. Amounts may differ due to rounding.

12. Assume 60% of expenditures are for the expanded population receiving RTS. Funding for this population is 50% GF and 50% Title XIX FFP.

$$\$42,376,000 \times 60\% = \$25,426,000 \text{ TF } (\$12,713,000 \text{ GF \& } \$12,713,000 \text{ FFP})$$

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

$$\$42,376,000 \times 10\% = \$4,238,000 \text{ TF } (\$2,119,000 \text{ GF \& } \$2,119,000 \text{ FFP})$$

14. Assume 30% of expenditures are for the ACA Optional Expansion non-perinatal population receiving RTS. Funding is 100% FF.

$$\$42,376,000 \times 30\% = \$12,713,000 \text{ FF}$$

15. 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.

<b>FY 2014-15</b>	<b>TF</b>	<b>FF Title XIX</b>	<b>FF Title XXI</b>	<b>CF</b>
<b>Current</b>				
Perinatal 50/50	\$1,666,000	\$833,000	\$0	\$833,000
Perinatal 65/35	\$27,000	\$0	\$18,000	\$9,000
<b>Mandatory</b>				
Perinatal 50/50	\$6,082,000	\$3,041,000	\$0	\$3,041,000
Perinatal 65/35	\$99,000	\$0	\$64,000	\$35,000
<b>Total</b>	<b>\$7,874,000</b>	<b>\$3,874,000</b>	<b>\$82,000</b>	<b>\$3,918,000</b>

**RESIDENTIAL TREATMENT SERVICES**

BASE POLICY CHANGE NUMBER: 65

<b>FY 2015-16</b>	<b>TF</b>	<b>FF Title XIX</b>	<b>FF Title XXI</b>	<b>CF</b>	<b>GF</b>
<b>Current</b>					
Perinatal 50/50	\$1,700,000	\$850,000	\$0	\$850,000	\$0
Perinatal 65/35	\$28,000	\$0	\$18,000	\$10,000	\$0
<b>Expanded</b>					
Regular	\$25,426,000	\$12,713,000	\$0	\$0	\$12,713,000
<b>Mandatory</b>					
Regular	\$4,238,000	\$2,119,000	\$0	\$0	\$2,119,000
Perinatal 50/50	\$9,126,000	\$4,563,000	\$0	\$4,563,000	\$0
Perinatal 65/35	\$148,000	\$0	\$96,000	\$52,000	\$0
<b>Optional</b>					
Regular	\$12,713,000	\$12,713,000	\$0	\$0	\$0
<b>Total</b>	<b>\$53,379,000</b>	<b>\$32,958,000</b>	<b>\$114,000</b>	<b>\$5,475,000</b>	<b>\$14,832,000</b>

**Funding:**

100% Title XIX (4260-101-0890)

100% Title XXI (4260-113-0890)

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

## SMHS FOR ADULTS

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$1,025,597,000	\$1,149,581,000
- STATE FUNDS	\$67,264,000	\$68,885,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,025,597,000	\$1,149,581,000
STATE FUNDS	\$67,264,000	\$68,885,000
FEDERAL FUNDS	\$958,333,000	\$1,080,696,000

### 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:**

The approved claims data has been updated to include six months of additional data.

#### **Methodology:**

1. The costs are developed using 70 months of SD/MC and 70 months of FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of December 31, 2014, with dates of service from December 2008 through September 2014. The FFS data is current as of December 31, 2014, with dates of service from October July 2008 through July 2014.
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 data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)			
	<b>Total</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2012-13	\$1,089,186	\$945,689	\$143,497
FY 2013-14	\$1,134,850	\$1,002,436	\$132,414
FY 2014-15	\$1,183,918	\$1,048,852	\$135,066
FY 2015-16	\$1,229,397	\$1,090,718	\$138,679

**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)			
	<b>Total</b>	<b>FF</b>	<b>CF</b>
FY 2012-13	\$1,089,186	\$544,593	\$544,593
FY 2013-14	\$1,134,850	\$567,425	\$567,425
FY 2014-15	\$1,183,918	\$591,959	\$591,959
FY 2015-16	\$1,229,397	\$614,699	\$614,698

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)			
	<b>Total</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2012-13	\$10,892	\$9,457	\$1,435
FY 2013-14	\$241,636	\$210,603	\$31,033
FY 2014-15	\$920,069	\$818,009	\$102,060
<b>Total FY 2014-15</b>	<b>\$1,172,597</b>	<b>\$1,038,069</b>	<b>\$134,528</b>

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)			
	<b>Total</b>	<b>SD/MC</b>	<b>FFS Inpatient</b>
FY 2013-14	\$11,348	\$10,024	\$1,324
FY 2014-15	\$252,010	\$220,355	\$31,655
FY 2015-16	\$955,453	\$850,662	\$104,791
<b>Total FY 2015-16</b>	<b>\$1,218,811</b>	<b>\$1,081,041</b>	<b>\$137,770</b>

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				
	<b>TF</b>	<b>FF</b>	<b>County</b>	<b>GF Reimbursement</b>
<b>Total FY 2014-15</b>	\$1,239,862	\$586,300	\$586,298	\$67,264
<b>Total FY 2015-16</b>	\$1,287,695	\$609,405	\$609,405	\$68,885

**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				
	<b>TF</b>	<b>FF</b>	<b>County</b>	<b>GF Reimbursement</b>
<b>Total FY 2014-15</b>	\$1,611,895	<b>\$958,333</b>	\$586,298	<b>\$67,264</b>
<b>Total FY 2015-16</b>	\$1,758,986	<b>\$1,080,696</b>	\$609,405	<b>\$68,885</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$939,189,000	\$992,419,000
- STATE FUNDS	\$39,209,000	\$43,095,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$939,189,000	\$992,419,000
STATE FUNDS	\$39,209,000	\$43,095,000
FEDERAL FUNDS	\$899,980,000	\$949,324,000

### 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 Medi-Cal managed care (MC) plans (by primary care providers within their scope of practice) or the fee-for-service (FFS) Medi-Cal program for beneficiaries not enrolled in a MC plan.

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 as of December 31, 2014.

#### **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, 2014, 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	\$1,563,705	\$1,499,707	\$63,998
FY 2013-14	\$1,681,877	\$1,605,660	\$76,217
FY 2014-15	\$1,761,079	\$1,677,773	\$83,306
FY 2015-16	\$1,850,580	\$1,761,037	\$89,543

## 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	\$1,563,705	\$799,340	\$764,365
FY 2013-14	\$1,681,877	\$864,957	\$816,920
FY 2014-15	\$1,761,079	\$909,652	\$851,427
FY 2015-16	\$1,850,580	\$959,112	\$891,468

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	\$15,637	\$14,997	\$640
FY 2013-14	\$355,197	\$337,335	\$17,862
FY 2014-15	\$1,371,458	\$1,308,509	\$62,949
<b>Total FY 2014-15</b>	<b>\$1,742,292</b>	<b>\$1,660,841</b>	<b>\$81,451</b>

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	\$16,819	\$16,057	\$762
FY 2014-15	\$372,010	\$352,486	\$19,524
FY 2015-16	\$1,441,111	\$1,373,449	\$67,662
<b>Total FY 2015-16</b>	<b>\$1,829,940</b>	<b>\$1,741,992</b>	<b>\$87,948</b>

**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
<b>Total FY 2014-15</b>	\$1,783,020	\$775,035	\$124,945	\$842,314	\$39,209
<b>Total FY 2015-16</b>	\$1,873,914	\$803,386	\$145,059	\$881,495	\$42,216

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$9,744,574,000</b>	<b>\$10,518,318,000</b>
<b>- STATE FUNDS</b>	<b>\$4,738,584,350</b>	<b>\$5,119,314,000</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$9,744,574,000</b>	<b>\$10,518,318,000</b>
<b>STATE FUNDS</b>	<b>\$4,738,584,350</b>	<b>\$5,119,314,000</b>
<b>FEDERAL FUNDS</b>	<b>\$5,005,989,650</b>	<b>\$5,399,004,000</b>

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 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. Eligibles increased 3.1% in FY 2014-15, and 4.2% in FY 2015-16. Rates have decreased by 0.1% in FY 2014-15, and increased by 2.2% in FY 2015-16. Hepatitis C dollars increased by 78% in FY 2014-15, and by 85% in FY 2015-16. LA Vision Pilot payments were included in the annual rate redetermination.

**Methodology:**

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

## TWO PLAN MODEL

### BASE POLICY CHANGE NUMBER: 109

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 115 Managed Care Rate Range IGTs. The base IGT capitation payments for Alameda County are budgeted in this policy change.
3. Rates have been redetermined for FY 2014-15 and FY 2015-16.
4. New adjustments to the annual rate redeterminations include:
  - LA Vision Pilot Project
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$266,270,000 for FY 2014-15 and \$421,030,000 for FY 2015-16 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$83,190,000 for FY 2014-15 and \$107,210,000 for FY 2015-16 were included in the rates. Rates include the savings for application to primary care physicians effective January 1, 2015.
7. Services provided through the LA Mobile Vision Pilot Project are included in the rates. These were previously budgeted in PC 53 Pediatric Mobile Vision Project.
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)

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	2,528,212	\$572,929
Contra Costa	1,623,953	\$501,704
Kern	2,568,707	\$402,968
Los Angeles	22,189,779	\$3,887,555
Riverside	5,215,037	\$816,738
San Bernardino	5,481,287	\$858,212
San Francisco	1,092,980	\$357,129
San Joaquin	2,018,090	\$331,641
Santa Clara	2,450,397	\$434,103
Stanislaus	1,558,563	\$331,302
Tulare	1,783,477	\$262,002
Fresno	3,376,544	\$700,179
Kings	392,342	\$84,162
Madera	483,444	\$79,300
Total	52,762,812	\$9,619,924
Hepatitis C Adjustment		\$124,650
<b>Total FY 2014-15</b>		<b>\$9,744,574</b>

(Dollars in Thousands)

<b>Included in the Above Dollars</b>	<b>FY 2014-15</b>
Mental Health	\$266,270
Blood Factor	(\$10,560)
AB 97	(\$83,190)

**TWO PLAN MODEL**  
**BASE POLICY CHANGE NUMBER: 109**

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>Eligible Months</b>	<b>Total</b>
Alameda	2,620,314	\$620,716
Contra Costa	1,697,669	\$525,299
Kern	2,635,607	\$447,840
Los Angeles	22,668,216	\$4,225,627
Riverside	5,493,597	\$879,058
San Bernardino	5,722,514	\$942,179
San Francisco	1,118,223	\$382,331
San Joaquin	2,084,711	\$368,747
Santa Clara	2,431,782	\$458,305
Stanislaus	1,593,841	\$335,807
Tulare	1,820,892	\$278,028
Fresno	3,429,051	\$755,279
Kings	403,496	\$84,763
Madera	496,996	\$84,719
Total	54,216,908	\$10,388,398
Heptatitis C Adjustment		\$129,620
<b>Total FY 2015-16</b>		<b>\$10,518,318</b>

(Dollars in Thousands)

<b>Included in the Above Dollars</b>	<b>FY 2015-16</b>
Mental Health	\$421,030
Blood Factor	(\$13,660)
AB 97	(\$107,210)
LA Mobile Vision Pilot Project	\$1,760

**Funding:**

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$8,970,779	\$4,485,390	\$4,485,390
State GF	\$18,869	\$18,869	\$0
Family Planning 90/10 GF	\$119,593	\$11,959	\$107,634
Title XXI 65/35 GF	\$635,333	\$222,367	\$412,966
<b>Total</b>	<b>\$9,744,574</b>	<b>\$4,738,585</b>	<b>\$5,005,990</b>

<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$9,711,806	\$4,855,903	\$4,855,903
State GF	\$19,067	\$19,067	\$0
Family Planning 90/10 GF	\$125,047	\$12,505	\$112,542
Title XXI 65/35 GF	\$662,398	\$231,839	\$430,559
<b>Total</b>	<b>\$10,518,318</b>	<b>\$5,119,314</b>	<b>\$5,399,004</b>

## COUNTY ORGANIZED HEALTH SYSTEMS

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$4,567,587,000	\$4,589,386,000
- STATE FUNDS	\$2,210,206,450	\$2,221,705,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,567,587,000	\$4,589,386,000
STATE FUNDS	\$2,210,206,450	\$2,221,705,300
FEDERAL FUNDS	\$2,357,380,550	\$2,367,680,700

### 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:**

Updated rates and eligibles. Eligibles increased by 4.2% in FY 2014-15, and by 3.1% in FY 2015-16. Rates decreased by 1% in FY 2014-15, and by 2.1% in FY 2015-16. Hepatitis C dollars increased by 120% in FY 2014-15, and by 135% in FY 2015-16. Abortion rates for Orange County were significantly lower than previously budgeted.

**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 115 Managed Care Rate Range IGTs. The base IGT capitation payments for San Mateo County are budgeted in this policy change.
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).
4. Rates have been redetermined for FY 2014-15 and FY 2015-16.
5. Capitation rate increases due to the MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy change.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$75,340,000 for FY 2014-15 and \$120,298,000 for FY 2015-16 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$19,433,000 for FY 2014-15 and \$29,235,000 for FY 2015-16 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.
8. The Department receives federal reimbursement of 90% for family planning services.
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.

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 111

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
501- San Luis Obispo	448,250	\$111,868
502- Santa Barbara	1,018,576	\$251,970
503- San Mateo	919,730	\$219,327
504- Solano	958,700	\$290,079
505- Santa Cruz	565,218	\$144,006
506-Orange	6,470,179	\$1,516,215
507- Napa	246,741	\$72,067
508-Monterey	1,318,012	\$280,343
509- Yolo	439,923	\$131,540
513- Sonoma	928,170	\$266,569
514- Merced	1,124,842	\$219,335
510 - Marin	290,731	\$102,015
512 - Mendocino	300,138	\$75,035
515 - Ventura	1,641,274	\$368,401
523 - Del Norte	99,460	\$29,689
517 - Humboldt	372,464	\$114,158
511 - Lake	243,288	\$71,363
518 - Lassen	61,914	\$19,151
519 - Modoc	26,374	\$9,920
520 - Shasta	541,415	\$177,847
521 - Siskiyou	139,336	\$39,022
522 - Trinity	36,901	\$11,497
Total FY 2014-15	18,191,637	\$4,521,417
Hepatitis C Adjustment		\$46,170
<b>Total with Adjustments</b>		<b>\$4,567,587</b>

(Dollars in Thousands)

<b>Included in Above Dollars</b>	<b>FY 2014-15</b>
Mental Health	\$75,340
Blood Factor	(\$19,976)
AB 97	(\$19,433)

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 111

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>Eligible Months</b>	<b>Total</b>
501- San Luis Obispo	453,042	\$116,450
502- Santa Barbara	1,040,367	\$270,589
503- San Mateo	884,058	\$214,401
504- Solano	987,693	\$285,866
505- Santa Cruz	574,358	\$139,685
506-Orange	6,656,676	\$1,496,258
507- Napa	257,154	\$77,945
508-Monterey	1,353,020	\$288,319
509- Yolo	452,248	\$131,687
513- Sonoma	956,757	\$265,116
514- Merced	1,148,327	\$238,141
510 - Marin	295,524	\$100,459
512 - Mendocino	305,919	\$78,678
515 - Ventura	1,657,663	\$363,084
523 - Del Norte	100,177	\$29,521
517 - Humboldt	378,497	\$115,025
511 - Lake	246,739	\$71,423
518 - Lassen	62,628	\$19,221
519 - Modoc	26,954	\$10,019
520 - Shasta	547,011	\$177,693
521 - Siskiyou	140,922	\$38,796
522 - Trinity	37,633	\$11,614
Total FY 2015-16	18,563,368	\$4,539,990
Hepatitis C Adjustment		\$49,396
<b>Total with Adjustments</b>		<b>\$4,589,386</b>

(Dollars in Thousands)

<b>Included in Above Dollars</b>	<b>FY 2015-16</b>
Mental Health	\$120,298
Blood Factor	(\$28,443)
AB 97	(\$29,235)

**COUNTY ORGANIZED HEALTH SYSTEMS**

BASE POLICY CHANGE NUMBER: 111

**Funding:**

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$4,155,138	\$2,077,569	\$2,077,569
State GF	\$2,387	\$2,387	\$0
Family Planning 90/10 GF	\$53,085	\$5,309	\$47,776
Title XXI 65/35 GF	\$356,977	\$124,942	\$232,035
<b>Total</b>	<b>\$4,567,587</b>	<b>\$2,210,207</b>	<b>\$2,357,380</b>

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$4,179,796	\$2,089,898	\$2,089,898
State GF	\$2,432	\$2,432	\$0
Family Planning 90/10 GF	\$52,520	\$5,252	\$47,268
Title XXI 65/35 GF	\$354,638	\$124,123	\$230,515
<b>Total</b>	<b>\$4,589,386</b>	<b>\$2,221,705</b>	<b>\$2,367,681</b>

## GEOGRAPHIC MANAGED CARE

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$1,862,393,000	\$2,050,257,000
- STATE FUNDS	\$902,681,150	\$994,887,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,862,393,000	\$2,050,257,000
STATE FUNDS	\$902,681,150	\$994,887,900
FEDERAL FUNDS	\$959,711,850	\$1,055,369,100

### 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. Eligibles increased by 5.2% in FY 2014-15, and by 7.7% in FY 2015-16. Rates decreased by 0.4% in FY 2014-15, and increased by 3.9% in FY 2015-16. Hepatitis C dollars increased by 162% in FY 2014-15, and by 185% in FY 2015-16.

**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.

**GEOGRAPHIC MANAGED CARE****BASE POLICY CHANGE NUMBER: 112**

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 115 Managed Care Rate Range IGTs.
3. Rates have been redetermined for FY 2014-15 and FY 2015-16.
4. 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.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$44,340,000 for FY 2014-15 and \$71,950,000 for FY 2015-16 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$15,760,000 for FY 2014-15 and \$20,480,000 for FY 2015-16 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.
7. 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.
8. 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.

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento	3,644,192	\$758,333
San Diego	5,056,170	\$1,075,280
Total	8,700,362	\$1,833,613
Hepatitis C Adjustment		\$28,780
<b>Total FY 2014-15</b>		<b>\$1,862,393</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2014-15</b>
Mental Health	\$44,340
Blood Factor	(\$1,890)
AB 97	(\$15,760)

**GEOGRAPHIC MANAGED CARE**

BASE POLICY CHANGE NUMBER: 112

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>Eligible Months</b>	<b>Total</b>
Sacramento	3,744,226	\$793,764
San Diego	5,333,365	\$1,225,113
Total	9,077,591	\$2,018,877
Heptatitis C Adjustment		\$31,380
<b>Total FY 2015-16</b>		<b>\$2,050,257</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2015-16</b>
Mental Health	\$71,950
Blood Factor	(\$4,560)
AB 97	(\$20,480)

**Funding:**

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$1,695,480	\$847,740	\$847,740
State GF	\$3,024	\$3,024	\$0
Family Planning 90/10 GF	\$21,776	\$2,178	\$19,598
Title XXI 65/35 GF	\$142,113	\$49,740	\$92,373
<b>Total</b>	<b>\$1,862,393</b>	<b>\$902,682</b>	<b>\$959,711</b>

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50	\$1,873,066	\$936,533	\$936,533
State GF	\$3,116	\$3,116	\$0
Family Planning 90/10 GF	\$22,750	\$2,275	\$20,475
Title XXI 65/35 GF	\$151,324	\$52,963	\$98,361
<b>Total</b>	<b>\$2,050,256</b>	<b>\$994,887</b>	<b>\$1,055,369</b>

## REGIONAL MODEL

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$579,530,000	\$750,730,000
- STATE FUNDS	\$279,653,050	\$365,171,550
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$579,530,000	\$750,730,000
STATE FUNDS	\$279,653,050	\$365,171,550
FEDERAL FUNDS	\$299,876,950	\$385,558,450

### 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 were mandatorily enrolled in December 2014. These SPDs were previously in PC 127 Managed Care Expansion to Rural Counties, but they are now in the base. Eligibles increased by 50% in FY 2014-15, primarily due to the inclusion of SPDs, and by 12% in FY 2015-16. Rates decreased by 0.4% in FY 2014-15, and increased by 3.4% in FY 2015-16. Hepatitis C dollars increased by 120% in FY 2014-15, and by 135% in FY 2015-16.

## REGIONAL MODEL

### BASE POLICY CHANGE NUMBER: 116

**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.
2. 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.
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 115 Managed Care Rate Range IGTs.
4. Rates have been redetermined for FY 2014-15 and FY 2015-16.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$21,044,000 for FY 2014-15 and \$37,042,000 for FY 2015-16 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$5,794,000 for FY 2014-15 and \$6,086,000 for FY 2015-16 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.
7. 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.
8. 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.
9. Effective December 1, 2014, all non-dual Seniors and Persons with Disabilities (SPDs) were required to enroll.

**REGIONAL MODEL**  
**BASE POLICY CHANGE NUMBER: 116**

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>Eligible Months</b>	<b>Total</b>
Alpine	1,636	\$1,619
Amador	44,109	\$8,919
Butte	495,670	\$114,405
Calaveras	65,502	\$18,465
Colusa	58,886	\$12,863
El Dorado	201,262	\$39,313
Glenn	77,310	\$15,688
Inyo	32,064	\$10,052
Mariposa	27,118	\$13,971
Mono	17,356	\$3,394
Nevada	128,625	\$28,330
Placer	340,192	\$62,740
Plumas	28,521	\$7,486
Sierra	3,880	\$5,199
Sutter	258,754	\$47,497
Tehama	172,060	\$36,736
Tuolumne	81,341	\$18,040
Yuba	193,332	\$42,155
Imperial	579,696	\$96,331
San Benito	67,870	\$9,486
<b>Total FY 2014-15</b>	<b>2,875,185</b>	<b>\$592,689</b>
Hepatitis C Adjustment		\$8,135
SPD deferral		(\$21,294)
<b>Total with Adjustments</b>		<b>\$579,530</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2014-15</b>
Mental Health	\$21,044
Blood Factor	(\$4,646)
AB 97	(\$5,794)

**REGIONAL MODEL**  
**BASE POLICY CHANGE NUMBER: 116**

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>Eligible Months</b>	<b>Total</b>
Alpine	1,648	\$1,707
Amador	46,532	\$10,953
Butte	548,288	\$156,638
Calaveras	69,973	\$22,097
Colusa	61,250	\$14,275
El Dorado	215,159	\$49,747
Glenn	81,701	\$18,989
Inyo	33,757	\$11,304
Mariposa	28,610	\$15,582
Mono	18,082	\$3,767
Nevada	136,608	\$34,891
Placer	363,084	\$78,096
Plumas	30,915	\$9,523
Sierra	4,002	\$5,597
Sutter	274,014	\$58,277
Tehama	184,897	\$48,098
Tuolumne	86,850	\$23,083
Yuba	208,362	\$54,615
Imperial	611,495	\$116,363
San Benito	68,195	\$8,425
Total FY 2015-16	3,073,421	\$742,027
Hepatitis C Adjustment		\$8,703
<b>Total with Adjustments</b>		<b>\$750,730</b>

(Dollars in Thousands)

<b>Included in Dollars Above</b>	<b>FY 2015-16</b>
Mental Health	\$37,042
Blood Factor	(\$6,008)
AB 97	(\$6,086)

**Funding:**

(Dollars in Thousands)

<b>FY 2014-15</b>		<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$521,535	\$260,768	\$260,768
State GF	4260-101-0001	\$1,107	\$1,107	\$0
Family Planning 90/10 GF	4260-101-0001/0890	\$8,529	\$853	\$7,676
OTLIPC 65/35 GF	4260-113-0001/0890	\$48,359	\$16,926	\$31,433
<b>Total</b>		<b>\$579,530</b>	<b>\$279,654</b>	<b>\$299,877</b>

**REGIONAL MODEL**  
**BASE POLICY CHANGE NUMBER: 116**

(Dollars in Thousands)

<b>FY 2015-16</b>		<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XIX 50/50 FFP	4260-101-0001/0890	\$692,213	\$346,107	\$346,107
State GF	4260-101-0001	\$1,129	\$1,129	\$0
Family Planning 90/10 GF	4260-101-0001/0890	\$8,599	\$860	\$7,739
OTLICP 65/35 GF	4260-113-0001/0890	\$48,789	\$17,076	\$31,713
<b>Total</b>		<b>\$750,730</b>	<b>\$365,172</b>	<b>\$385,559</b>

## PACE (Other M/C)

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$228,353,000	\$295,935,000
- STATE FUNDS	\$114,176,500	\$147,967,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$228,353,000	\$295,935,000
STATE FUNDS	\$114,176,500	\$147,967,500
FEDERAL FUNDS	\$114,176,500	\$147,967,500

### 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 ten contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. One new PACE organization 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.

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

**Reason for Change from Prior Estimate:**

Estimated enrollment projections decreased by 6% in FY 2014-15 and 10% in FY 2015-16 and a delay in implementation of 2015 PACE rates.

**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 effective January 2017.
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 occurred during the October 2014 capitation cycle. In October 2014, the Department received approval from the Centers for Medicare and Medicaid Services' (CMS) for contract amendments implementing 2014 PACE rates retroactive to January 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 occurred during the February 2015 capitation cycle.

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 119**

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 began with the October 2014 capitation cycle and is expected to be completed by the September 2015 capitation cycle.

6. In October 2014, the Department received CMS approval of contract amendments implementing 2014 PACE rates, retroactive to January 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 occurred during the February 2015 capitation cycle.
7. The Department anticipates receiving CMS approval of contract amendments implementing 2015 rates in June 2015, retroactive to January 2015. This results in a repayment of approximately \$5,375,000 for the increase of Medi-Cal Only and Dual rates that were paid at 2014 PACE rates from January to June 2015. The repayment is expected to occur during the July 2015 capitation cycle.

<b>FY 2014-15</b>	<b>TF Cost (Rounded)</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Centers for Elders' Independence	\$32,368,000	7,429	619
Sutter Senior Care	\$12,537,000	3,097	258
AltaMed Senior BuenaCare	\$75,535,000	19,722	1,643
OnLok (SF, Alameda and Santa Clara)	\$71,879,000	15,711	1,309
St. Paul's PACE	\$20,029,000	5,065	422
Los Angeles Jewish Homes	\$4,317,000	1,205	100
CalOptima PACE	\$2,288,000	623	52
InnovAge (San Bernardino and Riverside)	\$3,763,000	919	77
Redwood Coast	\$482,000	146	12
Central Valley Medical Services	\$3,477,000	791	66
San Ysidro San Diego	\$263,000	60	5
<b>Total Capitation Payments</b>	<b>\$226,938,000</b>	<b>54,769</b>	<b>4,563</b>
2013 Rate Repayment	\$4,182,000		
2014 Rate Repayment	\$6,024,000		
2013 Rate Recoupment	(\$8,744,000)		
2014 Rate Recoupment	(\$47,000)		
<b>Total FY 2014-15</b>	<b>\$228,353,000</b>		

**PACE (Other M/C)**  
**BASE POLICY CHANGE NUMBER: 119**

<b>FY 2015-16</b>	<b>TF Cost (Rounded)</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Centers for Elders' Independence	\$40,418,000	8,612	718
Sutter Senior Care	\$14,303,000	3,304	275
AltaMed Senior BuenaCare	\$84,904,000	20,778	1,732
OnLok (SF, Alameda and Santa Clara)	\$84,825,000	17,205	1,434
St. Paul's PACE	\$26,073,000	6,381	532
Los Angeles Jewish Homes	\$6,301,000	1,643	139
CalOptima PACE	\$5,291,000	1,305	109
InnovAge (San Bernardino and Riverside)	\$15,103,000	3,440	287
Redwood Coast	\$2,474,000	716	60
Central Valley Medical Services	\$9,621,000	2,048	171
San Ysidro San Diego	\$4,162,000	935	78
<b>Total Capitation Payments</b>	<b>\$293,475,000</b>	<b>66,367</b>	<b>5,533</b>
2013 Rate Recoupment	(\$2,915,000)		
2015 Rate Repayment	\$5,375,000		
<b>Total FY 2015-16</b>	<b>\$295,935,000</b>		

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$140,401,000	\$146,820,000
- STATE FUNDS	\$57,873,550	\$60,779,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$140,401,000	\$146,820,000
STATE FUNDS	\$57,873,550	\$60,779,700
FEDERAL FUNDS	\$82,527,450	\$86,040,300

**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 monthly eligibles. Costs for FY 2014-15 and FY 2015-16 have also increased due to the inclusion of the Health Insurance Providers Fee (HIPF), and ACA Optional, and Mandatory Expansion dollars. These were formerly included in the Dental FI cost reimbursement category, PC 18 ACA Optional Expansion and PC 19 ACA Mandatory Expansion.

### 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 is 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.
8. The HIPF was formerly included in the Dental Fiscal Intermediary cost reimbursement category. For FY 2014-15 and FY 2015-16, the impact is \$727,000 per fiscal year.
9. ACA Optional and Mandatory Expansion dollars were formerly included in PC 18 ACA Optional Expansion and PC 19 ACA Mandatory Expansion.

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

BASE POLICY CHANGE NUMBER: 120

(Dollars in Thousands)

<b>FY 2014-15</b>		<b>Average Monthly Eligibles</b>	
	<b>Capitation Rate</b>		<b>Total Funds</b>
GMC			
<21	\$12.13	219,506	\$31,951
21+	\$8.50	140,764	\$14,358
PHP			
<21	\$13.73	324,608	\$53,482
21+	\$7.88	149,996	\$14,184
			\$113,975
HIPF			\$727
ACA			
ACA Optional Dental			\$24,548
ACA Mandatory Dental			\$1,151
		<b>Total FY 2014-15</b>	<b>\$140,401</b>
Restoration of Select Adult Dental Benefits (included in above dollars)			
GMC	\$6.46	140,764	\$10,912
PHP	\$6.46	149,996	\$11,628
			\$22,540
\$1,800 Soft Cap (included in above dollars)			\$90

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

BASE POLICY CHANGE NUMBER: 120

(Dollars in Thousands)

<b>FY 2015-16</b>		<b>Average Monthly Eligibles</b>	
	<b>Capitation Rate</b>		<b>Total Funds</b>
GMC			
<21	\$12.13	235,330	\$34,255
21+	\$8.50	150,911	\$15,393
PHP			
<21	\$13.73	332,803	\$54,833
21+	\$7.88	153,782	\$14,542
			\$119,023
HIPF			\$727
ACA			
ACA Optional Dental			\$25,077
ACA Mandatory Dental			\$1,993
		<b>Total FY 2015-16</b>	<b>\$146,820</b>
Restoration of Select Adult Dental Benefits (included in above dollars)			
GMC	\$5.84	150,911	\$10,576
PHP	\$5.84	153,782	\$10,777
			\$21,353
\$1,800 Soft Cap (included in above dollars)			\$90

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XXI 65/35	\$353,000	\$124,000	\$229,000
50/50 Title XIX	\$115,590,000	\$57,795,000	\$57,795,000
100% Title XIX FFP	\$24,548,000	\$0	\$24,548,000
<b>Total</b>	<b>\$140,401,000</b>	<b>\$57,719,000</b>	<b>\$82,572,000</b>
<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XXI 65/35	\$612,000	\$214,000	\$398,000
50/50 Title XIX	\$121,131,000	\$60,566,000	\$60,566,000
100% Title XIX FFP	\$25,077,000	\$0	\$25,077,000
<b>Total</b>	<b>\$146,820,000</b>	<b>\$60,780,000</b>	<b>\$86,040,000</b>

**Funding:**

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

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

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

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

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$45,628,000	\$47,202,000
- STATE FUNDS	\$22,814,000	\$23,601,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,628,000	\$47,202,000
STATE FUNDS	\$22,814,000	\$23,601,000
FEDERAL FUNDS	\$22,814,000	\$23,601,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14200

**Interdependent Policy Changes:**

PC 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:**

Eligible months were updated with actuals from July 2014 through December 2014 increased by 7% for FY 2014-15 and FY 2015-16 and delayed implementation of 2015 SCAN rates.

**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 8,940 in December 2014 and 9,243 by June 2015 based on Medi-Cal enrollment projections submitted by SCAN.

**SENIOR CARE ACTION NETWORK (Other M/C)****BASE POLICY CHANGE NUMBER: 121**

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 and CY 2016 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 was paid 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 was paid in September 2014.
7. The Department anticipates receiving CMS approval of contract amendments implementing 2015 SCAN rates, retroactive from January 1, 2015, in June 2015. This will result in an estimated repayment of approximately \$856,000 for the increase to both the Aged/Disabled and LTC rate categories for each SCAN health plan code. The repayment is expected to occur during the July 2015 capitation cycle.

<b>FY 2014-15</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Los Angeles	\$29,111,000	71,676	5,973
Riverside	\$8,440,000	22,484	1,874
San Bernardino	\$6,145,000	14,353	1,196
<b>Total</b>	<b>\$43,696,000</b>	<b>108,513</b>	<b>9,043</b>
2013 Rate Repayment	\$305,000		
2014 Rate Repayment	\$1,627,000		
<b>Total FY 2014-15</b>	<b>\$45,628,000</b>		
<b>FY 2015-16</b>	<b>Costs</b>	<b>Eligible Months</b>	<b>Avg. Monthly Enrollment</b>
Los Angeles	\$30,224,000	72,017	6,001
Riverside	\$9,347,000	25,515	2,126
San Bernardino	\$6,775,000	15,990	1,333
<b>Total</b>	<b>\$46,346,000</b>	<b>113,522</b>	<b>9,460</b>
2015 Rate Repayment	\$856,000		
<b>Total FY 2015-16</b>	<b>\$47,202,000</b>		

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$9,338,000	\$7,003,000
- STATE FUNDS	\$4,669,000	\$3,501,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,338,000	\$7,003,000
STATE FUNDS	\$4,669,000	\$3,501,500
FEDERAL FUNDS	\$4,669,000	\$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 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 2014. This has resulted in an overpayment to the PCCM given a reduction in capitation rates in 2012, 2013, and 2014 relative to 2011. The Department has a contractual option to recoup the overpayments on a monthly basis, retroactive to January 2012. Recoupment is expected to begin FY 2015-16.

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

**AIDS HEALTHCARE CENTERS (Other M/C)****BASE POLICY CHANGE NUMBER: 125**

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:**

Recoupment of retroactive rate adjustments was delayed from FY 2014-15 to FY 2015-16.

**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:  $4,200 \times \$292.07 = \$1,227,000$

FY 15-16:  $4,200 \times \$292.07 = \$1,227,000$

**Medi-Cal Only:**

FY 14-15:  $5,400 \times \$1,502.07 = \$8,111,000$

FY 15-16:  $5,400 \times \$1,502.07 = \$8,111,000$

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

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dual	\$1,227	\$614	\$614
Medi-Cal Only	\$8,111	\$4,056	\$4,056
Recoupment	\$0	\$0	\$0
<b>Total</b>	<b>\$9,338</b>	<b>\$4,669</b>	<b>\$4,669</b>

<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Dual	\$1,227	\$614	\$614
Medi-Cal Only	\$8,111	\$4,056	\$4,056
Recoupment	(\$2,335)	(\$1,168)	(\$1,168)
<b>Total</b>	<b>\$7,003</b>	<b>\$3,502</b>	<b>\$3,502</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$989,000	\$976,000
- STATE FUNDS	\$494,500	\$488,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$989,000	\$976,000
STATE FUNDS	\$494,500	\$488,000
FEDERAL FUNDS	\$494,500	\$488,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Welfare & Institutions Code 14087.3

**Interdependent Policy Changes:**

PC 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 previously extended 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 535 for FY 2014-15 and 528 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: 535 x \$1,848.75 = **\$989,000 TF (\$494,000 GF)**

FY 2015-16: 528 x \$1,848.75 = **\$976,000 TF (\$488,000 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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$2,332,570,000</b>	<b>\$845,295,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$2,332,570,000</b>	<b>\$845,295,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$2,332,570,000</b>	<b>\$845,295,000</b>

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

SB 1008 enacted the Coordinated Care Initiative which requires, in part, to mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change 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:**

For FY 2014-15, this policy change budgeted the 50% FMAP for PC 23 – Community First Choice Option and PC 23 – Community First Choice Option budgeted the 6% enhanced FMAP. For FY 2015-16, the entire 56% FMAP is budgeted under PC 23 – Community First Choice Option.

**Methodology:**

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

(Dollars in Thousands)

	<u>TF</u>	<u>FFP</u>	<u>CDSS GF/ County Share</u>
<b>FY 2014-15</b>	\$4,665,140	<b>\$2,332,570</b>	\$2,332,570
<b>FY 2015-16</b>	\$1,690,590	<b>\$845,295</b>	\$845,295

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$2,583,363,000	\$2,618,021,000
- STATE FUNDS	\$1,388,999,500	\$1,408,764,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,583,363,000	\$2,618,021,000
STATE FUNDS	\$1,388,999,500	\$1,408,764,500
FEDERAL FUNDS	\$1,194,363,500	\$1,209,256,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

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

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

There is no material change in Medicare 2015 premiums and 2016 estimated premiums. Previous estimate and this estimate's premiums and Average Monthly Eligibles are shown below with actual premiums:

	2014	2015		2016	
	Actual	November 2014 Estimate	May 2015 Estimate Actual	November 2014 Estimate	May 2015 Estimate
		Premiums			
Part A	\$ 426.00	\$ 407.00	\$ 407.00	\$ 407.00	\$ 407.00
Part B	\$ 104.90	\$ 104.90	\$ 104.90	\$ 104.90	\$ 104.90
	Average Monthly Eligibles				
Part A		177,000	176,200	179,900	178,700
Part B		1,292,500	1,289,100	1,329,500	1,325,400

**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.

<b>FY 2014-15</b>	<b>Part A</b>	<b>Part B</b>
Average Monthly Eligibles	176,200	1,289,100
Rate 07/2014-12/2014	\$426.00	\$104.90
Rate 01/2015-06/2015	\$407.00	\$104.90
<b>FY 2015-16</b>		
Average Monthly Eligibles	178,700	1,325,400
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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$1,516,618,000	\$1,636,699,000
- STATE FUNDS	\$1,516,618,000	\$1,636,699,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,516,618,000	\$1,636,699,000
STATE FUNDS	\$1,516,618,000	\$1,636,699,000
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 <sup>2</sup>/<sub>3</sub>% each year until it reaches 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

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

<u>Calendar Year</u>	<u>PMPM rate</u>
2012	\$102.76
2013	\$103.70
2014	\$97.40
2015	\$98.76
2016	\$110.39 (estimated)

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

BASE POLICY CHANGE NUMBER: 169

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:**

- Updated 2015 and 2016 estimated PMPM growth. Prior estimate assumed PMPM in 2015 of \$99.13 and PMPM in 2016 of \$103.17. Actual 2015 is down to \$98.76 and the revised estimate for 2016 is up to \$110.39.
- The projected average monthly eligibles have declined since the November Estimate.

**Methodology:**

1. The 2014 Medicare Part D PMPM growth decreased 4.03% and Medi-Cal's estimated PMPM decreased to \$97.40.
2. The 2015 growth increased 3.65% over 2014 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2015 is \$98.76.
3. The 2016 growth is estimated to increase 11.76% based on the Part D 2015 annual percentage increase from *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM for 2016 is \$110.39.
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 – Jan 2015.
6. The Phased-down Contribution is funded 100% by State General Fund.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
<b>FY 2014-15</b>	12	1,291,491	\$126,384,811	<b>\$1,516,618,000</b>
<b>FY 2015-16</b>	12	1,328,431	\$136,391,549	<b>\$1,636,699,000</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$1,362,595,000</b>	<b>\$1,541,478,000</b>
<b>- STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$1,362,595,000</b>	<b>\$1,541,478,000</b>
<b>STATE FUNDS</b>	<b>\$0</b>	<b>\$0</b>
<b>FEDERAL FUNDS</b>	<b>\$1,362,595,000</b>	<b>\$1,541,478,000</b>

**DESCRIPTION****Purpose:**

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

**Authority:**

Interagency Agreement 01-15834

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

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

**Reason for Change from Prior Estimate:**

The estimated amounts for 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)	<b>Total</b>	<b>CDDS</b>	<b>DHCS</b>
	<b>Funds</b>	<b>GF</b>	<b>FFP</b>
<b>FY 2014-15</b>	\$2,725,189	\$1,362,594	<b>\$1,362,595</b>
<b>FY 2015-16</b>	\$3,082,957	\$1,541,479	<b>\$1,541,478</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
<b>FULL YEAR COST - TOTAL FUNDS</b>	<b>\$1,050,674,000</b>	<b>\$1,101,822,000</b>
<b>- STATE FUNDS</b>	<b>\$406,538,200</b>	<b>\$428,145,500</b>
<b>PAYMENT LAG</b>	<b>1.0000</b>	<b>1.0000</b>
<b>% REFLECTED IN BASE</b>	<b>0.00 %</b>	<b>0.00 %</b>
<b>APPLIED TO BASE</b>		
<b>TOTAL FUNDS</b>	<b>\$1,050,674,000</b>	<b>\$1,101,822,000</b>
<b>STATE FUNDS</b>	<b>\$406,538,200</b>	<b>\$428,145,500</b>
<b>FEDERAL FUNDS</b>	<b>\$644,135,800</b>	<b>\$673,676,500</b>

### 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 (Delta) 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 through February 2015. Costs for FY 2014-15 and FY 2015-16 have increased due to the inclusion of the Health Insurance Providers Fee (HIPF), and ACA Optional, and Mandatory Expansion dollars. These were formerly included in the Dental FI cost reimbursement category, PC 18 ACA Optional Expansion and PC 19 ACA Mandatory Expansion.

**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. The audit for the period ending June 30, 2013 resulted in an underwriting gain of \$34.2 million. According to the contract distribution provisions, the State will receive \$24.9 million and Delta will retain \$9.3 million in FY 2014-15.
3. For FY 2014-15 and FY 2015-16 the impact of the Restoration of Adult Dental Benefits is included in the capitation rates.
4. For FY 2014-15 and FY 2015-16 the impact of AB 97 is incorporated into the AB 97 policy change.
5. 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.
6. The HIPF was formerly included in the Dental Fiscal Intermediary cost reimbursement category. For FY 2014-15 and FY 2015-16, the impact is \$3,754,000 per fiscal year.
7. ACA Optional and Mandatory expansion dollars were formerly included in PC 18 ACA Optional Expansion and PC 19 ACA Mandatory Expansion. These dollars are now included in this policy change.

## DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

(Dollars in Thousands)

<b>FY 2014-15</b>	<b>Rate</b>	<b>Average Monthly Eligibles</b>	<b>Total Funds</b>
Regular 7/14 – 6/15	\$8.20	7,902,265	\$777,583
Refugee 7/14 – 6/15	\$5.94	1,781	\$127
Other FFS	Non-Capitated		\$91,360
		Subtotal	\$869,070
Underwriting Gain			(\$24,862)
		FY 2014-15 Dental	\$844,208
HIPF			\$3,754
ACA			
ACA Optional Dental			\$196,410
ACA Mandatory Dental			\$6,302
		<b>Total FY 2014-15</b>	<b>\$1,050,674</b>
Restoration of Select Adult Dental Benefits (included in above dollars)			
Regular	\$1.98	7,902,265	\$187,758
Refugee	\$3.91	1,781	\$84
			\$187,842
\$1,800 Soft Cap (included in above dollars)			\$1,290

## DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 171

(Dollars in Thousands)

<b>FY 2015-16</b>	<b>Rate</b>	<b>Average Monthly Eligibles</b>	<b>Total Funds</b>
Regular 7/15 – 6/16	\$8.20	8,010,920	\$788,275
Refugee 7/15 – 6/16	\$5.94	1,635	\$117
Other FFS	Non-Capitated		\$93,043
		FY 2015-16 Dental	\$881,435
HIPF			\$3,754
ACA			
ACA Optional Dental			\$205,448
ACA Mandatory Dental			\$11,185
		<b>Total FY 2015-16</b>	<b>\$1,101,822</b>
Restoration of Select Adult Dental Benefits (included in above dollars)			
Regular	\$1.98	8,010,920	\$190,339
Refugee	\$3.91	1,635	\$77
			\$190,416
\$1,800 Soft Cap (included in above dollars)			\$1,290

<b>FY 2014-15</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XXI 65/35	\$136,498,000	\$47,774,000	\$88,724,000
Enhanced Title XIX 65/35	\$834,000	\$292,000	\$542,000
100% GF	\$12,000	\$12,000	\$0
50/50 Title XIX	\$716,920,000	\$358,460,000	\$358,460,000
100% Title XIX FFP	\$196,410,000	\$0	\$196,410,000
<b>Total</b>	<b>\$1,050,674,000</b>	<b>\$406,538,000</b>	<b>\$644,136,000</b>
<b>FY 2015-16</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
Title XXI 65/35	\$132,816,000	\$46,486,000	\$86,330,000
Enhanced Title XIX 65/35	\$834,000	\$292,000	\$542,000
100% GF	\$12,000	\$12,000	\$0
50/50 Title XIX	\$762,712,000	\$381,356,000	\$381,356,000
100% Title XIX FFP	\$205,448,000	\$0	\$205,448,000
<b>Total</b>	<b>\$1,101,822,000</b>	<b>\$428,146,000</b>	<b>\$673,676,000</b>

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

## DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$245,500,000	\$206,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$245,500,000	\$206,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$245,500,000	\$206,500,000

### 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.

**DEVELOPMENTAL CENTERS/STATE OP SMALL FAC**

BASE POLICY CHANGE NUMBER: 172

**Methodology:**

1. The following estimates have been provided by CDDS.

<b>CASH BASIS</b>	<b>Total Funds</b>	<b>CDDS GF</b>	<b>FFP Regular</b>	<b>Interagency Agreement</b>
(In Thousands)				
<b>FY 2014-15</b>	\$491,000	\$245,500	<b>\$245,500</b>	03-75282
				03-75283
<b>FY 2015-16</b>	\$413,000	\$206,500	<b>\$206,500</b>	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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$195,908,000	\$162,286,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$195,908,000	\$162,286,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$195,908,000	\$162,286,000

### 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)

<b>CASH BASIS</b>	<b>Total Funds</b>	<b>CDDS GF</b>	<b>DHCS FFP</b>	<b>IA #</b>
<b>FY 2014-15</b>	\$391,816	\$195,908	<b>\$195,908</b>	03-75284
<b>FY 2015-16</b>	\$324,572	\$162,286	<b>\$162,286</b>	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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$41,535,000	\$47,090,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$41,535,000	\$47,090,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$41,535,000	\$47,090,000

### 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 the approved new SPAs and Affordable Care Act (ACA) additions.

**Methodology:**

1. SPA #10-010, approved on December 19, 2013, lifted the annual capitated amount (CAP removal) effective July 1, 2014. The annual capitated amount is the maximum amount in dollars an LGA could claim for reimbursement within a target population.
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, a 10% for a SPA increase (CAP removal), and approval of new SPAs 14-022, 14-023, and 14-024.

**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, 5% for a SPA increase (CAP removal), 5% for ACA encounters, and approval of new SPAs 14-022, 14-023, and 14-024.

Average Expenditures	\$36,959,000
2% Rate Increase	\$739,000
10% SPA Increase (CAP removal) 10-010	\$3,696,000
New SPA approvals 14-022, 14-023, 14-024	\$141,000
<b>FY 2014-15</b>	<b>\$41,535,000</b>

FY 2014-15 Estimate	\$41,535,000
2% Rate Increase	\$831,000
5% SPA Increase (CAP removal) 10-010	\$2,077,000
5% for ACA encounters	\$2,077,000
New SPA approvals 14-022, 14-023, 14-024	\$571,000
<b>FY 2015-16 *</b>	<b>\$47,090,000</b>

\*Total may differ due to rounding.

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$37,638,000	\$38,736,000
- STATE FUNDS	\$18,365,700	\$18,901,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$37,638,000	\$38,736,000
STATE FUNDS	\$18,365,700	\$18,901,500
FEDERAL FUNDS	\$19,272,300	\$19,834,500

### 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:**

A decrease in the number of screens has resulted in a lower projection of estimated expenditures.

**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 643,008 x \$58.53 (weighted average) = **\$37,638,000** (rounded)

**FY 2015-16**

Screens 659,722 x \$58.72 (weighted average) = **\$38,736,000** (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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$39,350,000	\$44,659,000
- STATE FUNDS	\$19,675,000	\$22,329,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$39,350,000	\$44,659,000
STATE FUNDS	\$19,675,000	\$22,329,500
FEDERAL FUNDS	\$19,675,000	\$22,329,500

### DESCRIPTION

**Purpose:**

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

**Authority:**

AB 668 (Chapter 896, Statutes of 1998)  
 Interagency Agreement (IA) 03-75898

**Interdependent Policy Changes:**

PC 40 California Community Transitions (CCT) 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 NF Level of Care Home and Community Based Services (HCBS) Waiver program. NF Level A/B, NF Subacute (SA), 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 IA 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 a \$.10 rate increase in FY 2014-15. For FY 2015-16, the rate increased by \$.24 and the total hours increased by 7.6%.

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

BASE POLICY CHANGE NUMBER: 179

**Methodology:**

1. Assume the number of current NF A/B LOC Waiver beneficiaries using WPCS 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 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 419 beneficiaries out of inpatient extended health care facilities during FY 2014-15, and 468 beneficiaries during FY 2015-16. Based on actual data from July 2013 through June 2014, 7% of the beneficiaries are expected to use WPCS.
4. The average cost/hour is \$10.46 for FY 2014-15 and \$10.60 FY 2015-16.
5. The chart below displays the estimate on an accrual basis.

<b>FY 2014-15</b>	<b>Total Hours</b>	<b>Cost/Hour</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
NF/AH Waiver					
NF A/B	2,428,913	\$10.46	\$25,406,435	\$12,703,217	\$12,703,217
NF S/A	1,221,658	\$10.46	\$12,778,545	\$6,389,273	\$6,389,273
IHO Waiver					
NF A/B	144,393	\$10.46	\$1,510,347	\$755,174	\$755,174
NF S/A	31,043	\$10.46	\$324,712	\$162,356	\$162,356
<b>Total</b>			<b>\$40,020,040</b>	<b>\$20,010,020</b>	<b>\$20,010,020</b>
<b>FY 2015-16</b>	<b>Total Hours</b>	<b>Cost/Hour</b>	<b>TF</b>	<b>GF</b>	<b>FF</b>
NF/AH Waiver					
NF A/B	2,792,919	\$10.60	\$29,604,942	\$14,802,471	\$14,802,471
NF S/A	1,332,261	\$10.60	\$14,121,967	\$7,060,984	\$7,060,984
IHO Waiver					
NF A/B	144,393	\$10.60	\$1,530,562	\$765,281	\$765,281
NF S/A	31,043	\$10.60	\$329,058	\$164,529	\$164,529
<b>Total</b>			<b>\$45,586,530</b>	<b>\$22,793,265</b>	<b>\$22,793,265</b>

6. The chart below is adjusted on a cash basis.

(Dollars in Thousands)	<b>TF</b>	<b>GF</b>	<b>FF</b>
<b>FY 2014-15</b>	<b>\$39,350</b>	<b>\$19,675</b>	<b>\$19,675</b>
<b>FY 2015-16</b>	<b>\$44,659</b>	<b>\$22,330</b>	<b>\$22,330</b>

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$7,921,000	\$3,690,000
- STATE FUNDS	\$3,960,500	\$1,845,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,921,000	\$3,690,000
STATE FUNDS	\$3,960,500	\$1,845,000
FEDERAL FUNDS	\$3,960,500	\$1,845,000

### 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:**

Additional lawsuits were added to FY 2015-16 (California Association of Rural Health Clinics and Saavedra).

**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

**LAWSUITS/CLAIMS****BASE POLICY CHANGE NUMBER: 183**

10. CFHS Holdings, Inc.	\$649
11. Alta Hospitals System	\$1,662
12. CFHS Holdings, Inc	\$1,717
13. Long Beach Memorial Medical Center	\$750
14. CFHS Holdings, Inc	\$1,356
15. AHMC Healthcare Inc	\$1,177
16. Adventist Health System, LLC	\$17,611
17. St Francis Medical Center	\$6,400
18. Farrow	\$1,000
<b>Total for FY 2014-15</b>	<b>\$137,020</b>

**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
<b>Total for FY 2014-15</b>	<b>\$566,056</b>

1. California Association of Rural Health Clinics	\$325,000
2. Saavedra	\$1,500,000
<b>Total for FY 2015-16</b>	<b>\$1,825,000</b>

**3. Other Provider Settlements / Judgments Payments**

1. Santa Clara County Health Authority	\$5,500,000
<b>Total for FY 2014-15</b>	<b>\$5,500,000</b>

	<b>Committed</b>	<b>Balance</b>	<b>Budgeted</b>	<b>Budgeted</b>
	<b>2014-15</b>	<b>2014-15</b>	<b>2014-15</b>	<b>2015-16</b>
Attorney Fees <\$5,000	\$0	\$41,450	\$41,450 *	\$50,000 *
Provider Settlements <\$75,000	\$137,020	\$1,462,980	\$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	\$1,825,000 *
Other Provider Settlements	\$5,500,000	N/A	\$5,500,000	\$0
Other Beneficiary Settlements	(\$2,000)	N/A	(\$2,000)	\$0
	<b>\$6,201,076</b>	<b>\$1,719,430</b>	<b>\$7,921,000</b>	<b>\$3,690,000</b>

\* Represents potential totals.

**Funding:**

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

## HIPP PREMIUM PAYOUTS (Misc. Svcs.)

**BASE POLICY CHANGE NUMBER:** 185  
**IMPLEMENTATION DATE:** 1/1993  
**ANALYST:** Cang Ly  
**FISCAL REFERENCE NUMBER:** 91

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$2,042,000	\$2,152,000
- STATE FUNDS	\$1,021,000	\$1,076,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,042,000	\$2,152,000
STATE FUNDS	\$1,021,000	\$1,076,000
FEDERAL FUNDS	\$1,021,000	\$1,076,000

### 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 HIPP program is a voluntary program for qualified beneficiaries with full scope Medi-Cal coverage. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) allowing the Department to revise the methodology for determining cost effectiveness under the HIPP program. Effective July 1, 2014, in addition to premiums, the Department will also pay for coinsurance, deductibles, and other cost sharing obligations when it is cost effective. HIPP program costs are budgeted separately from other Medi-Cal benefits since these are paid outside of the regular Medi-Cal claims payment procedures.

**Reason for Change from Prior Estimate:**

Based on updated data, HIPP program expenditures and enrollment have decreased resulting in lower average monthly premium costs.

**Methodology:**

1. Only premium costs are estimated as other cost sharing payments are not anticipated for the HIPP program.
2. In FY 2015-16, it is anticipated that there will be minimal growth in enrollment and the insurance premiums will increase by 5%.

**HIPP PREMIUM PAYOUTS (Misc. Svcs.)****BASE POLICY CHANGE NUMBER: 185**

3. The average monthly premium cost is estimated to be \$616.64 in FY 2014-15 and \$647.48 in FY 2015-16.
4. The average monthly HIPP enrollment is estimated to be 276 in FY 2014-15 and 277 in FY 2015-16.
5. Costs for FY 2014-15 and FY 2015-16 are estimated to be:

**FY 2014-15:**  $\$616.64 \times 276 \times 12 \text{ Months} = \$2,042,000 \text{ TF } (\$1,021,000 \text{ GF})$

**FY 2015-16:**  $\$647.48 \times 277 \times 12 \text{ Months} = \$2,152,000 \text{ TF } (\$1,076,000 \text{ GF})$

**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

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	\$1,799,000	\$1,285,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,799,000	\$1,285,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,799,000	\$1,285,000

### DESCRIPTION

**Purpose:**

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

**Authority:**

Interagency Agreement (IA) #07-65689

**Interdependent Policy Changes:**

Not Applicable

**Background:**

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

**Reason for Change from Prior Estimate:**

There is no change from prior estimate.

**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

(Dollars in Thousands)

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

<b>FY 2015-16</b>	<b>DHCS FFP</b>	<b>CDPH CLPP Fee Funds</b>
Benefits Costs	<b>\$1,285</b>	\$1,285

**Funding:**

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

## BASE RECOVERIES

**BASE POLICY CHANGE NUMBER:** 195  
**IMPLEMENTATION DATE:** 7/1987  
**ANALYST:** Celine Donaldson  
**FISCAL REFERENCE NUMBER:** 127

	<u>FY 2014-15</u>	<u>FY 2015-16</u>
FULL YEAR COST - TOTAL FUNDS	-\$297,905,000	-\$277,433,000
- STATE FUNDS	-\$149,948,000	-\$139,644,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$297,905,000	-\$277,433,000
STATE FUNDS	-\$149,948,000	-\$139,644,000
FEDERAL FUNDS	-\$147,957,000	-\$137,789,000

### DESCRIPTION

**Purpose:**

This policy change estimates estate, personal injury insurance, provider/beneficiary overpayment, and other insurance collections used to offset the cost of Medi-Cal services.

**Authority:**

- Welfare & Institutions Code 14009, 14009.5, 14124.70 – 14124.795, 14124.88, 14124.90-14124.94, 14172, 14172.5, 14173, 14176, and 14177
- Probate Code Sections 215, 9202, 19202, 3600-3605, and 3610-3613
- Title 22, California Code of Regulations Chapter 2.5 and Sections 50781-50791, 51045, 51047, and 51458.1

**Interdependent Policy Changes:**

Not Applicable

**Background:**

Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. These recoveries result from collections from estate, personal injury provider/beneficiary overpayment, and other health 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 one-time provider audit collections (\$15M in October and \$16M in December 2014) and increased health insurance recoveries due to the increase in Medi-Cal eligibles resulting from the federal mandatory requirement for health insurance. The increase in health insurance recoveries is expected to continue in FY 2015-16

**BASE RECOVERIES****BASE POLICY CHANGE NUMBER: 195**

(Dollars in Thousands)

	<b>FY 2014-15</b>	<b>FY 2015-16</b>
Personal Injury Collections	(\$56,434)	(\$51,975)
Workers' Comp. Contract	(\$1,212)	(\$1,788)
H.I. Contingency Contract	(\$78,975)	(\$73,500)
General Collections	(\$161,283)	(\$150,169)
<b>TOTAL</b>	<b>(\$297,905)</b>	<b>(\$277,433)</b>

**Methodology:**

1. The recoveries estimate uses the trend in the monthly recoveries for July 2011 – December 2014.
2. The General Fund ratio for collections is estimated to be 50.33% in FY 2014-15 and FY 2015-16.

**Funding:**

100% GF (4260-101-0001)

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