MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	ELIGIBILITY
1	FAMILY PACT PROGRAM
2	BREAST AND CERVICAL CANCER TREATMENT
4	MEDI-CAL ADULT INMATE PROGRAMS
6	MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES
7	PREGNANT WOMEN FULL SCOPE EXPANSION 60-138%
8	COUNTY HEALTH INITIATIVE MATCHING (CHIM)
10	MEDI-CAL ACCESS PROGRAM 30 WEEK CHANGE
11	NEW QUALIFIED IMMIGRANTS
12	RESOURCE DISREGARD - % PROGRAM CHILDREN
13	SCHIP FUNDING FOR PRENATAL CARE
14	CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN
15	INCARCERATION VERIFICATION PROGRAM
16	PARIS-VETERANS
17	TLICP PREMIUMS
211	FEDERAL IMMIGRATION REFORM
218	UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION
	AFFORDABLE CARE ACT
18	ACA OPTIONAL EXPANSION
19	ACA MANDATORY EXPANSION
20	ACA EXPRESS LANE ENROLLMENT
21	PAYMENTS TO PRIMARY CARE PHYSICIANS
22	ACA HOSPITAL PRESUMPTIVE ELIGIBILITY
23	COMMUNITY FIRST CHOICE OPTION
24	ACA DELAY OF REDETERMINATIONS
25	ACA EXPANSION-NEW QUALIFIED IMMIGRANTS
26	HEALTH INSURER FEE
27	ACA EXPANSION-ADULT INMATES INPT. HOSP. COSTS
29	1% FMAP INCREASE FOR PREVENTIVE SERVICES
30	STATE-ONLY FORMER FOSTER CARE PROGRAM
31	ACA MAGI SAVINGS
32	RECOVERY AUDIT CONTRACTOR SAVINGS
34	MANAGED CARE DRUG REBATES
200	ACCELERATED ENROLLMENT
210	ACA REDETERMINATIONS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	AFFORDABLE CARE ACT
216	ACA EXPANSION-ADDITIONAL CHIP FUNDING
	BENEFITS
35	ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS
36	BEHAVIORAL HEALTH TREATMENT
37	LOCAL EDUCATION AGENCY (LEA) PROVIDERS
38	MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA
39	CCS DEMONSTRATION PROJECT PILOTS
40	CALIFORNIA COMMUNITY TRANSITIONS COSTS
41	DENTAL CHILDREN'S OUTREACH AGES 0-3
42	VOLUNTARY INPATIENT DETOXIFICATION
43	YOUTH REGIONAL TREATMENT CENTERS
44	CCT FUND TRANSFER TO CDSS AND CDDS
45	PEDIATRIC PALLIATIVE CARE WAIVER
46	SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER
47	QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS
48	IMPLEMENT AAP BRIGHT FUTURES PERIODICITY FOR EPSDT
49	CHDP PROGRAM DENTAL REFERRAL
50	WOMEN'S HEALTH SERVICES
51	CALIFORNIA COMMUNITY TRANSITIONS SAVINGS
201	ALLIED DENTAL PROFESSIONALS ENROLLMENT
202	PEDIATRIC PALLIATIVE CARE EXPANSION AND SAVINGS
	PHARMACY
52	RESTORATION OF ENTERAL NUTRITION BENEFIT
54	NON FFP DRUGS
55	BCCTP DRUG REBATES
56	MEDICAL SUPPLY REBATES
57	LITIGATION SETTLEMENTS
58	FAMILY PACT DRUG REBATES
59	STATE SUPPLEMENTAL DRUG REBATES
60	AGED AND DISPUTED DRUG REBATES
61	FEDERAL DRUG REBATE PROGRAM
215	HEPATITIS C REVISED CLINICAL GUIDELINES

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	DRUG MEDI-CAL
66	DRUG MEDI-CAL PROGRAM COST SETTLEMENT
67	ANNUAL RATE ADJUSTMENT
68	PROVIDER FRAUD IMPACT TO DMC PROGRAM
	MENTAL HEALTH
71	ELIMINATION OF STATE MAXIMUM RATES
72	TRANSITION OF HFP - SMH SERVICES
73	KATIE A. V. DIANA BONTA
74	INTERIM AND FINAL COST SETTLEMENTS - SMHS
75	INVESTMENT IN MENTAL HEALTH WELLNESS
76	HEALTHY FAMILIES - SED
77	OVER ONE-YEAR CLAIMS
78	SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT
79	SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT
80	IMD ANCILLARY SERVICES
81	CHART REVIEW
	WAIVER--MH/UCD & BTR
82	MH/UCD & BTR—DSH PAYMENT
83	BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL
84	MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT
85	BTR - LIHP - MCE
86	MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT
87	BTR—SAFETY NET CARE POOL
88	MH/UCD & BTR—CCS AND GHPP
89	LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND
90	BTR - LOW INCOME HEALTH PROGRAM - HCCI
91	MH/UCD & BTR—DPH INTERIM & FINAL RECONS
92	MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST
93	BTR—DESIGNATED STATE HEALTH PROGRAMS
94	MH/UCD & BTR—DPH INTERIM RATE GROWTH
95	MH/UCD—SAFETY NET CARE POOL
96	BTR—INCREASE SAFETY NET CARE POOL
97	MH/UCD—STABILIZATION FUNDING
98	BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	WAIVER--MH/UCD & BTR
99	BTR - LIHP - DSRIP HIV TRANSITION PROJECTS
100	MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT
101	UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG
102	MH/UCD—HEALTH CARE COVERAGE INITIATIVE
103	MH/UCD & BTR—BCCTP
104	MH/UCD & BTR—DPH INTERIM RATE
105	MH/UCD & BTR—MIA-LTC
106	BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS
107	MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP
108	BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS
	MANAGED CARE
110	CCI-MANAGED CARE PAYMENTS
113	CCI-TRANSFER OF IHSS COSTS TO CDSS
114	MCO TAX MGD. CARE PLANS - INCR. CAP. RATES
115	MANAGED CARE RATE RANGE IGTS
117	MANAGED CARE PUBLIC HOSPITAL IGTS
118	RETRO MC RATE ADJUSTMENTS
122	BLOOD FACTOR CARVE OUT
123	EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES
124	MANAGED CARE EXPANSION TO RURAL COUNTIES
126	NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS
128	CAPITATED RATE ADJUSTMENT FOR FY 2015-16
129	MANAGED CARE IGT ADMIN. & PROCESSING FEE
130	GENERAL FUND REIMBURSEMENTS FROM DPHS
131	EXTEND GROSS PREMIUM TAX
132	EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT
133	FFS COSTS FOR MANAGED CARE ENROLLEES
134	MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT
135	MCO TAX MANAGED CARE PLANS
136	CCI-SAVINGS AND DEFERRAL
203	HQAF RATE RANGE INCREASES
213	HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS
	PROVIDER RATES

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	PROVIDER RATES
137	FQHC/RHC/CBRC RECONCILIATION PROCESS
138	QUALITY AND ACCOUNTABILITY SUPPLEMENTAL PAYMENTS
139	AB 1629 RATE ADJUSTMENTS DUE TO QA FEE
140	EMERGENCY MEDICAL AIR TRANSPORTATION ACT
141	AB 1629 ADD-ONS
142	LTC RATE ADJUSTMENT
143	DENTAL RETROACTIVE RATE CHANGES
144	ANNUAL MEI INCREASE FOR FQHCS/RHCS
145	GENETIC DISEASE SCREENING PROGRAM FEE INCREASE
146	HOSPICE RATE INCREASES
147	LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES
148	LABORATORY RATE METHODOLOGY CHANGE
149	NON-AB 1629 LTC RATE FREEZE
150	10% PAYMENT REDUCTION FOR LTC FACILITIES
151	REDUCTION TO RADIOLOGY RATES
152	DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY
153	10% PROVIDER PAYMENT REDUCTION
217	ELIMINATION OF DENTAL PROVIDER PAYMENT REDUCTIONS
	SUPPLEMENTAL PMNTS.
154	EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS
155	HOSPITAL QAF - HOSPITAL PAYMENTS
156	GEMT SUPPLEMENTAL PAYMENT PROGRAM
157	CAPITAL PROJECT DEBT REIMBURSEMENT
158	HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENTS
159	NDPH IGT SUPPLEMENTAL PAYMENTS
160	FFP FOR LOCAL TRAUMA CENTERS
161	CERTIFICATION PAYMENTS FOR DP-NFS
162	IGT PAYMENTS FOR HOSPITAL SERVICES
163	FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS
164	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH
165	MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH
166	STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS
207	MARTIN LUTHER KING JR. COMMUNITY HOSPITAL PAYMENTS

MEDI-CAL PROGRAM REGULAR
POLICY CHANGE INDEX

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
173	ARRA HITECH - PROVIDER PAYMENTS
175	ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS
176	NONCONTRACT HOSP INPATIENT COST SETTLEMENTS
180	AUDIT SETTLEMENTS
181	ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS
182	REIMBURSEMENT FOR IHS/MOA 638 CLINICS
184	OVERTIME FOR WPCS PROVIDERS
186	CDDS DENTAL SERVICES
188	INDIAN HEALTH SERVICES
189	HOMEMAKER SERVICES - AIDS MEDI-CAL WAIVER
190	EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE
191	CIGARETTE AND TOBACCO SURTAX FUNDS
192	CLPP FUND
193	CCI-TRANSFER OF IHSS COSTS TO DHCS
194	IHSS REDUCTION IN SERVICE HOURS
199	WPCS WORKERS' COMPENSATION
212	COUNTY SHARE OF OTLICP-CCS COSTS

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER:	114
IMPLEMENTATION DATE:	7/2014
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1781

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$1,407,405,000	$1,062,016,000
- STATE FUNDS	$479,186,000	$371,706,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,407,405,000	$1,062,016,000
STATE FUNDS	$479,186,000	$371,706,000
FEDERAL FUNDS	$928,219,000	$690,310,000

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by Managed Care Organization (MCO) tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

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

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, Regional, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be continuously appropriated for the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates the cost of the capitation rate increases.

Reason for Change from Prior Estimate:
New baseline rates have been developed for FY 2014-15 and FY 2015-16.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 114

Methodology:

1. The MCO tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the tax.

2. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

3. The premium revenue was multiplied by the MCO tax amount of 3.9375% to determine total tax revenue.

4. Capitation rate increases due to the MCO tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from Fund 3156 on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd Care Plans–Funding Adjustment policy change.

5. The costs of capitation rate increases related to the imposition of the MCO tax are expected to be:

(Dollars in Thousands)	TF	GF (MCO Tax)	FFP
FY 2014-15	**$1,407,405**	**$479,186**	**$928,219**
FY 2015-16	**$1,062,016**	**$371,706**	**$690,310**

Funding:

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

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	134
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1782

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

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

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, Regional, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be retained by the Department to offset GF cost for capitated rate increases as a result of the imposition of the tax. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change from Prior Estimate:
New baseline rates have been developed for FY 2014-15 and FY 2015-16.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 134

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

6. The MCO tax fund transfers to the GF are expected to be:

(Dollars in Thousands)	TF	GF	MCO Tax*
FY 2014-15	**$0**	**($442,188)**	**$442,188**
FY 2015-16	**$0**	**($398,577)**	**$398,577**

Funding:
100% State GF (4260-101-0001)
*3156 Gross Premium Tax (Non-GF) (4260-601-3156)

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER:	135
IMPLEMENTATION DATE:	7/2013
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1783

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2013.

Authority:
SB 78 (Chapter 33, Statutes of 2013)

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

Background:
SB 78 was signed by the Governor on June 27, 2013, and provides for a statewide tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, Regional, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

The MCO tax is effective July 1, 2013, through June 30, 2016. One half of the tax revenue will be continuously appropriated to the Department solely for the purposes of funding managed care rates for health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program that reflect the cost of services and acuity of the population served. This policy change estimates GF savings resulting from the imposition of the MCO tax.

Reason for Change from Prior Estimate:
New baseline rates have been developed for FY 2014-15 and FY 2015-16.

Methodology:
1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 135

2. The premium revenue was multiplied by the MCO tax rate of 3.9375% to determine total tax revenue.

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.

4. Assume a three-month lag between when tax payments are paid to the Board of Equalization and when they are transferred to the Department.

5. The impact of the increase in capitation payments related to the tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

6. The MCO tax fund transfers to the GF are expected to be:

(Dollars in Thousands)	TF	GF	MCO Tax
FY 2014-15	**$0**	**($807,421)**	**$807,421**
FY 2015-16	**$0**	**($1,112,250)**	**$1,112,250**

Funding:
100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	153
IMPLEMENTATION DATE:	12/2011
ANALYST:	Sharisse DeLeon
FISCAL REFERENCE NUMBER:	1580

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$260,474,000	-$228,177,000
- STATE FUNDS	-$130,237,000	-$114,088,500
PAYMENT LAG	0.9939	1.0000
% REFLECTED IN BASE	43.69 %	51.64 %
APPLIED TO BASE		
TOTAL FUNDS	-$145,778,200	-$110,346,400
STATE FUNDS	-$72,889,100	-$55,173,200
FEDERAL FUNDS	-$72,889,100	-$55,173,200

DESCRIPTION

Purpose:
This policy change estimates savings due to the implementation of the provider payment reduction pursuant to Assembly Bill (AB) 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)

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

Background:
AB 97 requires the Department to implement up to a 10% provider payment reduction, which will affect all services except:

- Hospital inpatient and outpatient services, critical access hospitals, federal rural referral centers,
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs),
- Services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs,
- Hospice services,
- Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services, and
- Payments funded by certified public expenditures and intergovernmental transfers.

Effective March 1, 2009, as required by AB 1183, Pharmacy and Long-Term Care (LTC) provider payments were reduced by 5%. Other fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

specified providers. A recent court decision vacated the preliminary injunctions clearing the way for the Department to implement the payment reductions.

The actuarial equivalent of FFS payment reductions to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The impact of AB 97 for managed care will be determined on a prospective basis.

SB 75 (Chapter 18, Statutes of 2015), exempts dental providers from the 10% provider payment reductions, effective July 1, 2015. See the Elimination of Dental Provider Payment Reductions policy change for more information.

Reason for Change from Prior Estimate:

- Recoupment implementation for DME/Medical Supplies and Pharmacy shifted from March 2015 to April 2016 due to competing priority and workload issues for the Fiscal Intermediary.
- Updated Pharmacy data based on actual 24 months claim expenditures.
- Phase I: Transitioning Adult Day Health Care (ADHC) program into Community-Based Adult Services (CBAS) is complete. Costs associated with CBAS are budgeted in the managed care related policy changes.
- Phase I: Exempt Pediatric Day Health Care (PDHC) program for the period of June 1, 2011 to March 31, 2012
- Remove FY 2015-16 managed care savings: FY 2015-16 managed care rates already incorporated the payment reduction to primary care physicians.
- Update Dental expenditures based on new caseload and include dental managed care savings.

Methodology:

1. **Managed Care:** There is no retroactive savings for managed care payments and the implementation of the managed care reductions began October 1, 2013. The impact of AB 97 for managed care is budgeted in the managed care related policy changes, except for the savings from primary care physicians, which are subject to the Affordable Care Act (ACA) payment increase. The following services are not subject to a reduction:
   - Pharmacy, and
   - Specialty physician services.

2. **FFS**: The Department implements the FFS payment reductions in three phases.

   - **Phase I**: Phase I includes all subject providers except for the previously enjoined providers and the Child Health and Disability Prevention (CHDP) program.

     - PDHC program was first exempted on October 25, 2012, from the 10% payment reduction, effective April 1, 2012. PDHC providers were refunded in July 2013 for the payment reduction for services provided after April 1, 2012. In October 2014, PDHC providers were exempted further for the period of June 1, 2011 to March 31, 2012 and refunded any payment reductions applied for this period.
     - The Department received CMS approval on August 28, 2013 to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012. The Department stopped the 10% payment reduction in November 2013 and refunded the

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

payment reduction for the period October 19, 2012 through October 31, 2013 in September 2014.

- o Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in August 2013 and refunded the payment reduction for the period June 1, 2011 through August 31, 2013 in May 2014.
- o Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in December 2013 and refunded the payment reduction for the period June 1, 2011 through November 30, 2013 in August 2014.

- **Phase II**: Phase II includes all the previously enjoined providers.

  - o Nonprofit dental pediatric surgery centers that provide at least 99% of their services under general anesthesia to children with severe dental disease under age of 21 are exempt from the 10% payment reduction effective August 31, 2013.
  - o For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 are exempt from the 10% payment reduction effective December 1, 2013.
  - o Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions are exempt from the 10% payment reduction effective March 31, 2012.

- **Phase III**: Phase III includes the CHDP program providers.

3. The Department forgoes the retroactive recoupments prior to the corresponding implementation date for the following providers: Physicians, medical transportation, dental, clinics, certain high-cost drugs, and CHDP.

Provider Type	Payment Reduction Effective Date	Payment Reduction Implementation Date	Total Months of Retroactive Period	Recoupment Start Date	Total Months to Recoup
Phase I	6/1/2011	12/20/2011	7	6/29/2012	24
Phase II					
Physicians	1/10/2014	1/10/2014	N/A	N/A	N/A
Medical Transportation	9/5/2013	9/5/2013	N/A	N/A	N/A
DME/Medical Supplies	6/1/2011	10/24/2013	29	4/1/2016	63
Dental	9/5/2013	9/5/2013	N/A	N/A	N/A
Clinics	1/10/2014	1/10/2014	N/A	N/A	N/A
Pharmacy	6/1/2011	2/7/2014	32	4/1/2016	66
Phase III (CHDP)	10/1/2014	10/1/2014	N/A	N/A	N/A

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

4. The estimated savings from AB 97 payment reduction are:

		Total Fund		
(Dollars In Thousands)		**FY 2014-15**	**FY 2015-16**	**Annual**
Phase I	FFS	($22,266)	($29,175)	($29,175)
	FFS Retro	$0	$0	$0
	Phase I Total	($22,266)	($29,175)	
Phase II				
Physicians	FFS	($49,746)	($49,746)	($49,746)
	FFS Retro	$0	$0	$0
Medical Transportations	FFS	($14,461)	($14,461)	($14,461)
	FFS Retro	$0	$0	$0
DME/Medical Supplies	FFS	($17,394)	($17,394)	($17,394)
	FFS Retro	$0	($1,878)	($7,510)
Dental	FFS	($60,044)	($60,044)	($60,044)
	FFS Retro	$0	$0	$0
Clinics	FFS	($18,512)	($18,512)	($18,512)
	FFS Retro	$0	$0	$0
Pharmacy	FFS	($30,891)	($30,891)	($30,891)
	FFS Retro	$0	($3,663)	($14,650)
	FFS	($191,048)	($191,048)	($191,048)
	FFS Retro	$0	($5,540)	($22,160)
	Phase II Total	($191,048)	($196,588)	
Phase III (CHDP)	FFS	($1,811)	($2,414)	($2,414)
	FFS Retro	$0	$0	$0
	Phase III Total	($1,811)	($2,414)	
	FFS	($215,124)	($222,638)	($222,638)
	FFS Retro	$0	($5,540)	($22,160)
	Managed Care	($45,350)	$0	$0
	Grand Total	**($260,474)**	**($228,178)**	($244,798)

5. Implementation for DME/Medical Supplies and Pharmacy recoupment will begin as soon as the CA-MMIS system is operationally ready.

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

OVERTIME FOR WPCS PROVIDERS

REGULAR POLICY CHANGE NUMBER: 184
IMPLEMENTATION DATE: 10/2015
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1852

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

DESCRIPTION

Purpose:
This policy change estimates the cost of paying Waiver Personal Care Services (WPCS) providers, overtime and travel time.

Authority:
Welfare & Institutions Code, Section 12300.4

Interdependent Policy Changes:
Not Applicable

Background:
New federal regulations require IHSS and WPCS employees to be paid overtime. Therefore, there will be additional costs for the Department related to the WPCS policy change. The Welfare & Institutions Code, Section 12300.4 identifies two additional costs to the IHSS and WPCS Program. These new areas include overtime and travel time for IHSS/WPCS providers. Based on statute, an IHSS/WPCS provider cannot exceed 66 hours in a workweek: a 40 hour workweek and 26 hours of overtime. Travel time is defined as time spent traveling directly from a location where authorized services are provided to one recipient, to another location where authorized services are to be provided to another recipient.

Reason for Change from Prior Estimate:
Assumes implementation on October 1, 2015.

Methodology:
1) The estimated cost for overtime and travel time for WPCS providers is $3,000,000 TF in FY 2015-16.

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

ANNUAL HEALTH PLAN OPEN ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 196
IMPLEMENTATION DATE: 11/2015
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1882

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	-$5,939,000
- STATE FUNDS	$0	-$2,969,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$5,939,000
STATE FUNDS	$0	-$2,969,500
FEDERAL FUNDS	$0	-$2,969,500

DELETED

DESCRIPTION

Purpose:
This policy change estimates the fiscal impact of implementing an annual open enrollment plan for Medi-Cal managed care beneficiaries, excluding seniors and persons with disabilities (SPDs), dual eligible beneficiaries receiving full scope Medicare and Medi-Cal, new adult expansion population and any other category of mandatorily enrolled beneficiaries which the director, after receiving stakeholder input, determines should not be subject to the annual open enrollment process.

Authority:
Proposed Legislation

Interdependent Policy Changes:
PC 114 MCO Tax Mgd. Care Plans - Incr. Cap Rates
PC 134 MCO Tax Mgd. Care Plans - Funding Adjustment
PC 135 MCO Tax Managed Care Plans
OA PC 86 HCO Annual Health Plan Open Enrollment Costs

Background:
Currently, managed care enrollees may change plans on a monthly basis. This policy fosters frequent changes throughout the year which adversely affect continuity of care. The Department is proposing legislation to change the managed care enrollment policy to allow enrollees not mentioned above in Two-Plan and Geographic Managed Care counties to change plans on an annual basis. This change is consistent with the policy in most large group health plans such as CalPERS. New beneficiaries will have 90 days from their initial enrollment date to select or change their managed care plan. On an annual basis, existing members will be provided a 90-day period to change plans.

Currently, managed care plans are required to perform a health assessment each time a new beneficiary enrolls into their plan. Plans will now be required to share health records when beneficiaries switch plans.

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

ANNUAL HEALTH PLAN OPEN ENROLLMENT

REGULAR POLICY CHANGE NUMBER: 196

Methodology:

1. Assume the initial open enrollment period will be implemented November 15, 2015. From November 15, 2015, through February 15, 2016, existing plan members may elect to change their plan. Any plan changes will be effective March 1, 2016. Thereafter, plan members will have a 90-day period each year to change plans. New beneficiaries will continue to have 90 days from their initial enrollment date to select or change their managed care plan.

2. From February 16, 2016, through November 14, 2016, routine plan changes will not be allowed.

3. It is assumed that most health assessments will no longer be required when an existing beneficiary changes plans. The new plan will rely on the initial health assessment of the previous plan. The average cost of an assessment is $68.00.

4. Of the estimated 164,400 beneficiaries changing plans each year, it is assumed 85% will no longer require a health assessment and the remaining 15% will still require an additional assessment.
   - 164,400 assessments x 85% x $68.00 = $9,502,000 TF ($4,751,500 GF) annual savings
   - $9,502,000 x .625 (November 15, 2015, to June 30, 2016) = $5,939,000 ($2,969,500 GF) FY 2015-16 savings

5. Upon implementation, an initial notification will be mailed to approximately 3,200,000 beneficiaries informing them of their open enrollment period. There will be two additional mailings. Additionally, information packets will be mailed upon request to those beneficiaries who will change plans by mail. These costs are budgeted in OA PC 86 HCO Annual Open Enrollment Costs.

6. The savings for FY 2015-16 are expected to be:

(Dollars in Thousands)

FY 2015-16	TF	GF
Health Assessment Savings	**($5,939)**	**($2,970)**
Mailing & Related Costs (HCO)	$3,930	$1,965
Total	($2,009)	($1,005)

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

DELETED

MCO ENROLLEE TAX

REGULAR POLICY CHANGE NUMBER:	204
IMPLEMENTATION DATE:	10/2015
ANALYST:	Candace Epstein
FISCAL REFERENCE NUMBER:	1896

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on Managed Care Organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2015.

Authority:
Proposed legislation

Interdependent Policy Changes:
PC 205 MCO Enrollee Tax – Funding Adjustment
PC 206 MCO Enrollee Tax – Increase Capitation Rates

Background:
Currently, the state imposes an MCO tax on an MCO plan's gross revenue from Medi-Cal. This tax and the corresponding capitation rate increases and GF offsets are budgeted in PCs 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates, 134 MCO Tax Mgd. Care Plans – Funding Adjustment, and 135 MCO Tax Managed Care Plans.

The federal Centers for Medicare and Medicaid Services (CMS) issued guidance in July 2014 regarding Health Care-Related Taxes, which indicates California's existing MCO tax is inconsistent with federal Medicaid regulations because it only applies narrowly to Medi-Cal managed care plans. The current MCO tax is a significant source of federal funding for the Medi-Cal program which offsets General Fund (GF) spending by $803 million in FY 2014-15 and $1.1 billion in FY 2015-16. CMS advises that the MCO tax be brought in compliance with federal law by August 30, 2016.

The new MCO tax structure would meet the federal requirements while achieving the same savings to the Department's GF budget while also providing sufficient funding to restore the 7% reduction in the Department of Social Services' In-Home Supportive Services program. The tax will be implemented beginning the first quarter of FY 2015-16 and will be ongoing, replacing the current MCO tax which would end June 30, 2015.

DELETED

MCO ENROLLEE TAX

REGULAR POLICY CHANGE NUMBER: 204

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

Methodology:

1. Calculate the amount of tax that each non-exempt plan would pay. The tax is tiered, and is based on the quarterly member months for each plan:
   - $3.56 per beneficiary up to 125,000 member months.
   - $25.25 for each beneficiary between 125,001 and 275,000 member months.
   - $13.75 for each beneficiary between 275,001 and 1,250,000 member months.
   - $5.50 for each beneficiary between 1,250,001 and 2,500,000 member months.
   - $0.84 for each beneficiary beyond 2,500,001 member months.

2. Calculate the total taxed amount for non-exempt plans.

3. Calculate the amount of each plan's Medi-Cal beneficiaries as a percentage of the plan's total non-Medicare beneficiaries using data reported to the Department by the plans. Until plans begin submitting data, the Department will use data submitted to the Department of Managed Health Care for the first quarter of FY 2014-15.

4. Using the plan's Medi-Cal percentage, calculate the plan's capitation rate increases as a portion of the tax collected.

5. Subtract the GF portion of the capitation rate increases to calculate the transfer to the GF.

6. Assume a one quarter lag in collections.

7. The MCO tax fund transfers to the GF are expected to be:

(Dollars in Thousands)	TF	GF	MCO Tax*
FY 2015-16	**$0**	**($850,173)**	**$850,173**

Funding:
100% State GF (4260-101-0001)
*3156 MCO Tax (Non-GF) (4260-601-3156)

DELETED

MCO ENROLLEE TAX - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 205
IMPLEMENTATION DATE: 10/2015
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1897

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

DESCRIPTION

Purpose:
This policy change estimates the transfer of funds collected from the tax on managed care organizations (MCOs) to the General Fund (GF) to be used by the department to fund related managed care capitation rate increases.

Authority:
Proposed legislation

Interdependent Policy Changes:
PC 204 MCO Enrollee Tax
PC 206 MCO Enrollee Tax – Increase Capitation Rates

Background:
Currently, the state imposes an MCO tax on an MCO plan's gross revenue from Medi-Cal. This tax and the corresponding capitation rate increases and GF offsets are budgeted in PCs 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates, 134 MCO Tax Mgd. Care Plans – Funding Adjustment, and 135 MCO Tax Managed Care Plans.

The federal Centers for Medicare and Medicaid Services (CMS) issued guidance in July 2014 regarding Health Care-Related Taxes, which indicates California's existing MCO tax is inconsistent with federal Medicaid regulations because it only applies narrowly to Medi-Cal managed care plans. The current MCO tax is a significant source of federal funding for the Medi-Cal program which offsets General Fund (GF) spending by $803 million in FY 2014-15 and $1.1 billion in FY 2015-16. CMS advises that the MCO tax be brought into compliance with federal law by August 30, 2016.

The new MCO tax structure would meet the federal requirements while achieving the same savings to the Department's GF budget while also providing sufficient funding to restore the 7% reduction in the Department of social Services' In-Home Supportive Services program. The tax will be implemented beginning the first quarter of FY 2015-16 and will be ongoing, replacing the current MCO tax which would end June 30, 2015.

DELETED

MCO ENROLLEE TAX - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 205

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

Methodology:

1. Calculate the amount of tax that each non-exempt plan would pay. The tax is tiered, and is based on the quarterly member months for each plan:
   - $3.56 per beneficiary up to 125,000 member months,
   - $25.25 for each beneficiary between 125,001 and 275,000 member months,
   - $13.75 for each beneficiary between 275,001 and 1,250,000 member months,
   - $5.50 for each beneficiary between 1,250,001 and 2,500,000 member months,
   - $0.84 for each beneficiary beyond 2,500,001 member months.

2. Calculate the total taxed amount for non-exempt plans.

3. Calculate the amount of each plan's Medi-Cal beneficiaries as a percentage of the plan's total non-Medicare beneficiaries using data reported to the Department by the plans. Until plans begin submitting data, the Department will use data submitted to the Department of Managed Health Care for the first quarter of FY 2014-15.

4. Using the plan's Medi-Cal percentage, calculate the plan's capitation rate increases as a portion of the tax collected.

5. Calculate the GF portion of the plan's capitation rate increases. This is the amount that will be transferred to the GF to offset the capitation rate increases reflected in PC 206 MCO Enrollee Tax – Capitation Rate Increases.

6. Assume a one quarter lag for collections.

7. The MCO tax fund transfers to the GF are expected to be:

(Dollars in Thousands)	TF	GF	MCO Tax*
FY 2015-16	**$0**	**($278,780)**	**$278,780**

Funding:
100% State GF (4260-101-0001)
*3156 MCO (Non-GF) (4260-601-3156)

DELETED

MCO ENROLLEE TAX - INCREASE CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 206
IMPLEMENTATION DATE: 7/2015
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1898

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$1,062,016,000
- STATE FUNDS	$0	$371,705,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$1,062,016,000
STATE FUNDS	$0	$371,705,500
FEDERAL FUNDS	$0	$690,310,500

DELETED

DESCRIPTION

Purpose:
This policy change estimates the cost of capitation rate increases that are offset by Managed Care Organization (MCO) Enrollee Tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:
Proposed legislation

Independent Policy Changes:
PC 204 MCO Enrollee Tax
PC 205 MCO Enrollee Tax – Funding Adjustment

Background:
Currently, the state imposes an MCO tax on an MCO plan's gross revenue from Medi-Cal. This tax and the corresponding capitation rate increases and GF offsets are budgeted in PCs 114 MCO Tax Mgd. Care Plans – Incr. Cap. Rates, 134 MCO Tax Mgd. Care Plans – Funding Adjustment, and 135 MCO Tax Managed Care Plans.

The federal Centers for Medicare and Medicaid Services (CMS) issued guidance in July 2014 regarding Health Care-Related Taxes, which indicated California's existing MCO tax is inconsistent with federal Medicaid regulations because it only applies narrowly to Medi-Cal managed care plans. The current MCO tax is a significant source of federal funding for the Medi-Cal program which offsets General Fund (GF) spending by $803 million in FY 2014-15 and $1.1 billion in FY 2015-16. CMS advises that the MCO tax be brought into compliance with federal law by August 30, 2016.

The new MCO tax structure would meet the federal requirements while achieving the same savings to the Department's GF budget while also providing sufficient funding to restore the 7% reduction in the Department of Social Services' In-Home Supportive Services program. The tax will be implemented during the first quarter of FY 2015-16 and will be ongoing, replacing the current MCO tax which would end June 30, 2015.

MCO ENROLLEE TAX - INCREASE CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 206

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

Methodology:

1. Calculate the amount of tax that each non-exempt plan would pay. The tax is tiered, and is based on the quarterly member months for each plan:
   - $3.56 per beneficiary up to 125,000 member months.
   - $25.25 for each beneficiary between 125,001 and 275,000 member months.
   - $13.75 for each beneficiary between 275,001 and 1,250,000 member months.
   - $5.50 for each beneficiary between 1.250,001 and 2,500,000 member months.
   - $0.84 for each beneficiary beyond 2,500,001 member months.

2. Calculate the total taxed amount for non-exempt plans.

3. Calculate the amount of each plan's Medi-Cal beneficiaries as a percentage of the plan's total non-Medicare beneficiaries using data reported to the Department by the plans. Until plans begin submitting data, the Department will use data submitted to the Department of Managed Health Care for the first quarter of FY 2014-15.

4. Using the plan's Medi-Cal percentage, calculate the plan's capitation rate increases as a portion of the tax collected.

5. The costs of capitation rate increases related to the imposition of the MCO tax are expected to be:

(Dollars in Thousands)	TF	GF	FF
FY 2015-16	**$1,062,010**	**$371,700**	**$690,310**

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

DELETED

ACA REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER:	210
IMPLEMENTATION DATE:	12/2014
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1904

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	-$129,098,000	-$796,842,000
- STATE FUNDS	-$54,009,000	-$333,361,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	9.80 %	1.50 %
APPLIED TO BASE		
TOTAL FUNDS	-$116,446,400	-$784,889,400
STATE FUNDS	-$48,716,120	-$328,360,580
FEDERAL FUNDS	-$67,730,280	-$456,528,780

DESCRIPTION

Purpose:
This policy change estimates the savings related to restarting the annual Medi-Cal redetermination process, which in 2014 had previously been delayed or modified. These redetermination delays and modifications increased actual 2014 enrollment which is now captured in our base estimate.

Authority:
42 CFR 435.916(a)
Welfare & Institutions Code Section 14012

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

Background:
Effective January 1, 2014, the Department postponed annual redeterminations for 5-months for Medi-Cal beneficiaries who will be subject to the new MAGI standard and several non-MAGI groups. This 5-month delay helped provide counties with additional time to process the new incoming ACA expansion beneficiaries.

Effective June 1, 2014, the Department implemented a temporary modified renewal process for 6-months for Medi-Cal beneficiaries also subject to the new MAGI standard and several non-MAGI groups. The modified renewal process will only negatively impact those beneficiaries who do not complete the required renewal forms. If the beneficiary completes the renewal process, regardless of eligibility status, the beneficiary will retain coverage until their next scheduled renewal.

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

ACA REDETERMINATIONS

REGULAR POLICY CHANGE NUMBER: 210

Methodology:

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

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

3. The Department estimates 85,505 ineligible beneficiaries retained Medi-Cal coverage as result of the delays and modifications in the redetermination process.

4. Assume 2014 Medi-Cal redeterminations were completed in December 2014.

5. Total estimated FY 2014-15 and FY 2015-16 savings:

(Dollars in Thousands)	**TF**	**GF**	**FF**
FY 2014-15	**($129,098)**	($54,009)	($75,089)
FY 2015-16	**($796,842)**	($333,361)	($463,481)

Funding:

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

FEDERAL IMMIGRATION REFORM

REGULAR POLICY CHANGE NUMBER:	211
IMPLEMENTATION DATE:	10/2015
ANALYST:	Joanne Peschko
FISCAL REFERENCE NUMBER:	1905

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$20,883,000
- STATE FUNDS	$0	$16,779,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$20,883,000
STATE FUNDS	$0	$16,779,000
FEDERAL FUNDS	$0	$4,104,000

DESCRIPTION

Purpose:
This policy change estimates the impact of President Obama's deferred action executive order issued on November 20, 2014. This order expands the population eligible for the Deferred Action for Childhood Arrivals (DACA) and also creates the Deferred Action for Parents of U.S. Citizens and Lawful Permanent Residents (DAPA) program.

Authority:
Not Applicable

Interdependent Policy Changes:
Not Applicable

Background:
On November 20, 2014, President Obama issued an executive order on immigration policy which expanded the existing DACA program and created the DAPA program. Under these executive actions, it is estimated that more than one million undocumented Californian immigrants would be potentially eligible for a reprieve from deportation and work authorization. Currently, Medi-Cal provides full-scope coverage to individuals found eligible under the Permanently Residing Under Color of Law (PRUCOL) immigration statuses and to Qualified Aliens who are under the 5-year bar. For both groups, FFP is only available for emergency and pregnancy related services. Non-emergency services are funded with 100% State GF. One of the eligible PRUCOL statuses is deferred action.

The existing DACA program began in 2012 and offers work authorization and deportation relief to undocumented immigrants who:

- Came to the United States prior to turning 16 years old;
- Were under the age of 31 as of June 15, 2012;
- Have continuously resided in the United States since June 15, 2007, up to the present time;
- Were physically present in the United States on June 15, 2012;
- Had no lawful status on June 15, 2012;

FEDERAL IMMIGRATION REFORM

REGULAR POLICY CHANGE NUMBER: 211

- Are currently in school, have graduated or obtained a certificate of completion from high school, have obtained a general education development (GED) certificate, or are an honorably discharged veteran of the Coast Guard or Armed Forces of the United States; and
- Have not been convicted of a felony, significant misdemeanor, or three or more other misdemeanors, and do not otherwise pose a threat to national security or public safety.

Under the executive order, there would no longer be an age cap, the cut-off date for entry into the US would be moved to January 1, 2010 and deferred action would be extended to 3 rather than 2 years.

The new DAPA program is geared toward the parents of citizens and lawful permanent residents who have lived in the US for at least 5 years. This also would offer deferred action and employment authorization for 3 years. To be eligible the following must be met:

- Be the parent of a U.S. citizen or lawful permanent resident;
- Have continuously lived in the U.S. since January 1, 2010;
- Have been present in the U.S. on November 20, 2014;
- Not have a lawful immigration status on November 20, 2014;
- Have not been convicted of certain criminal offenses, including any felonies and some misdemeanors.

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

Methodology:

1) Assume implementation of both the expansion of DACA and the implementation of DAPA is October 1, 2015.

2) Per a 2014 study by the Migration Policy Institute (MPI), assume 1,221,000 people are eligible for the expanded DACA or new DAPA programs in California.

3) Of those eligible, 55% are estimated to apply for the new deferred action status.
   - 1,221,000 x 55% to apply = 671,706 applicants

4) Of those who apply, it is estimated that 80.8% will be approved for either expanded DACA or DAPA.
   - 671,706 applicants x 80.8% = 542,792 approved applicants

5) Of those who are approved, it is estimated that 43.8% will have incomes less than 138% of the federal poverty level (FPL) and will be eligible for Medi-Cal coverage.
   - 542,792 x 43.8% = 237,664 approved applicants with incomes <138% FPL

6) The Department estimates 155,874 of the existing restricted scope Medi-Cal population will become eligible for the new deferred action status. It is estimated they will shift into the full-scope coverage options, once eligible under their deferred action status.

7) The Department estimates the average per-member-per-month (PMPM) costs for the PRUCOL population in FY 2015-16 will be $274.54. The estimated restricted scope PMPM in FY 2015-16 is $148.51.

8) The Department estimates the take-up of Medi-Cal coverage through a phase-in approach. This phase-in will occur over a 24 month period.

FEDERAL IMMIGRATION REFORM

REGULAR POLICY CHANGE NUMBER: 211

9) The estimated FY 2015-16 costs are:

(Dollars in Thousands)	FY 2015-16		
	TF	**GF**	**FF**
Net Impact to the State	**$20,883**	**$16,779**	**$4,104**

Funding:
50% Title XIX / 50% GF (Emergency/Pregnancy Services)
100% State GF (Non-Emergency Services)

ELIMINATION OF DENTAL PROVIDER PAYMENT REDUCTIONS

REGULAR POLICY CHANGE NUMBER: 217
IMPLEMENTATION DATE: 7/2015
ANALYST: Sharisse DeLeon
FISCAL REFERENCE NUMBER: 1912

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$60,044,000
- STATE FUNDS	$0	$30,022,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$60,044,000
STATE FUNDS	$0	$30,022,000
FEDERAL FUNDS	$0	$30,022,000

DESCRIPTION

Purpose:
This policy change estimates the costs of exempting dental providers from the Assembly Bill (AB) 97 (Chapter 3, Statutes of 2011) provider payment reductions.

Authority:
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
AB 97 requires the Department to implement up to a 10% provider payment reduction to various providers, including dental providers. SB 75 (Chapter 18, Statutes of 2015), exempts dental providers from the 10% payment reductions, effective July 1, 2015.

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

Methodology:
1. Assume the effective date will be July 1, 2015.

2. Total costs from the dental provider exemption are estimated to be $60.044 million TF.

(Dollars in Thousands)

	TF	GF	FF
FY 2015-16	**$60,044**	**$30,022**	**$30,022**

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

UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER:	218
IMPLEMENTATION DATE:	5/2016
ANALYST:	Ryan Witz
FISCAL REFERENCE NUMBER:	1913

	FY 2014-15	FY 2015-16
FULL YEAR COST - TOTAL FUNDS	$0	$40,000,000
- STATE FUNDS	$0	$40,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$40,000,000
STATE FUNDS	$0	$40,000,000
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the action taken by the Legislature to expand full-scope Medi-Cal benefits to children under the age of 19 years, regardless of immigration status.

Authority:
SB 75 (Chapter 18, Statutes of 2015)

Interdependent Policy Changes:
Not Applicable

Background:
Currently, California provides limited-scope Medi-Cal coverage (emergency and pregnancy related services only) to many low income undocumented children. Federal Financial Participation (FFP) is available today, regardless of immigration status, for emergency and pregnancy related services. As result of this action, beginning in FY 2015-16 eligible undocumented children will receive full-scope Medi-Cal coverage instead of limited-scope coverage. California will continue to receive FFP for the emergency and pregnancy related services; however, any non-emergency services provided will be ineligible for FFP and funded solely by the State's General Fund.

Additionally, the May 2015 Medi-Cal Estimate includes the Federal Immigration Reform policy change, which per President Obama's executive order expands the existing Deferred Action for Childhood Arrivals (DACA) program. The expansion of the DACA program will grant deportation relief for many undocumented children and as result, they could be found eligible for full-scope Medi-Cal coverage under the Permanently Residing Under Color of Law (PRUCOL) immigration statuses. FFP is restricted to emergency and pregnancy related services only for Medi-Cal beneficiaries found eligible under the PRUCOL immigration statuses for their first 5-years in the country. After residing in the country for 5-years, FFP is available for all of their eligible services if the beneficiary takes the steps to become documented and they continue to meet all applicable eligibility requirements.

UNDOCUMENTED CHILDREN FULL SCOPE EXPANSION

REGULAR POLICY CHANGE NUMBER: 218

There is some overlap between populations eligible for the DACA expansion (assuming the court injunction is lifted) and those now eligible for full-scope Medi-Cal coverage under the Legislative action. This policy change estimates the net impact as result of the DACA expansion.

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

Methodology:
1) Assume the implementation of full-scope coverage for eligible undocumented children is May 1, 2016.

2) The Department estimates there are 170,000 undocumented children under the age 19 who are eligible for Medi-Cal. Of which, 114,981 are currently enrolled in restricted-scope Medi-Cal coverage.

3) The Department estimates the existing 114,981 restricted-scope Medi-Cal children will transition to full-scope Medi-Cal in May 2016.

4) Of the remaining 55,019 undocumented children under the age of 19 who are currently eligible but not enrolled, the Department estimates 50% will take up coverage over 12-months.

5) The estimated FY 2015-16 costs are:

(Dollars in Thousands)	**FY 2015-16**		
	TF	**GF**	**FF**
Net Impact to the State	$40,000	$40,000	$0

Funding:
100% State GF